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The Newsweekly for Pharmacy

C&D

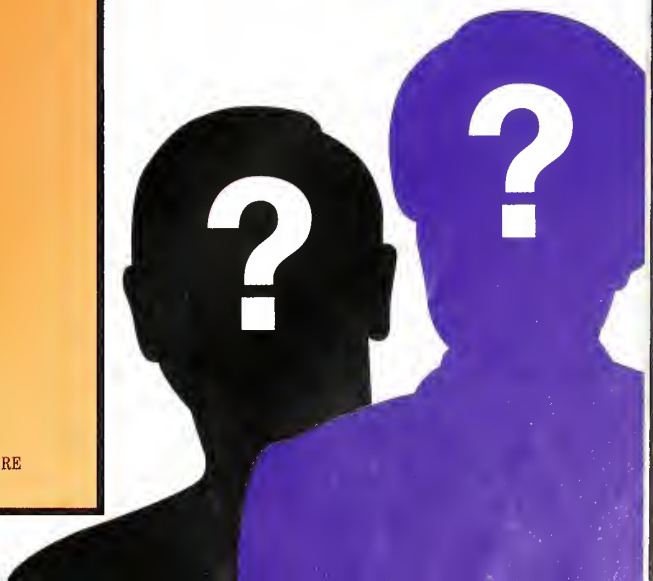
4 May 2002

LPS guidance says be ready for June 28

Pharmacy role in community care is set out

NPA challenge to findings of death inquiry

Who wants to be a Council member? You decide...



There are easier ways to clear a hayfever head

Nothing beats Beconase Hayfever for getting rid of blocked up, groggy hayfever heads.[1]

Unlike antihistamines, Beconase Hayfever has a direct anti-inflammatory action on the whole hayfever response.[2] That's why it relieves that unpleasant groggy headed feeling as well as classic hayfever symptoms.

Help put a stop to hayfever heads, eyes and noses. Start Beconase Hayfever, clear and simple.

BECONASE hayfever™

beclomethasone dipropionate

CUTTING HAYFEVER DOWN TO SIZE

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Beconase Hayfever Product Information:
Presentation: Aqueous nasal spray containing 50 micrograms beclomethasone dipropionate per spray. **Uses:** Allergic rhinitis. **Dosage and administration:** Intranasal use only *Adults aged 18 and over:* Two sprays into each nostril every morning and evening. **Contraindications:** Hypersensitivity. **Precautions:** If symptoms have not improved after 14 days use consult a doctor. Do not use continuously for longer than 3 months without consulting a doctor. Risk of adrenal suppression with use of higher than recommended doses. Precaution in presence of nasal infection. Avoid in pregnancy and lactation, unless otherwise directed by a doctor. **Side effects:** Dryness and irritation of the nose and throat, unpleasant smell and taste and epistaxis have been reported rarely. Rare cases of raised intraocular pressure or glaucoma and nasal septal perforation have been reported. **Hypersensitivity reactions:** Systemic effects may occur, particularly when used at high doses for prolonged periods. **Legal category:** P. **Retail selling price:** (ex VAT) 100 spray £5.10; 180 spray £7.65. **Product licence number:** 10949/0093. **Licence holder:** Allen & Hanburys Limited, Uxbridge, Middlesex UB11 1BT. Further information available on request from Medical and Consumer Affairs GlaxoSmit Consumer Healthcare U.K., GSK House, Brentford, Mid TW8 9GS. **Date of preparation:** March 2001. BEC HAYFEVER is a trademark of the GlaxoSmithKline Gro Companies. © GlaxoSmithKline, 2001.

References: 1. Weiner *et al.* Br Med J 1998; **317**: 1
2. International Rhinitis Management Working Group. Interna consensus report on the diagnosis and management of r Allergy 1994; **49**(suppl 19): s1-s34.

www.dotpharmacy.com

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This Week

Pharmacy

Regulars

Features

POLICY

Deadline for LPS proposals is June 28

Proposals for the first wave of local pharmaceutical services pilots must be submitted by June 28, according to LPS guidance issued by the Department of Health last Friday.

LPS proposals submitted by June 28 are expected to be up and running by Christmas; pilots proposed by the second deadline, November 1, by April 2003. Further waves will be announced.

The DoH guidance details issues to be addressed by those interested in participating in LPS pilots. It covers LPS objectives, terms of service, proposals and approval process, designation, assessment of LPS impact, preparation costs, pilot costs and funding, payments to LPS providers and review and evaluation of LPS schemes.

The official guidance is consistent with the LPS information issued last week by the National Pharmaceutical Association (*C&D, April 27, p37*) and with the content of a draft Statutory Instrument for LPS that was circulated last month (*C&D, April 27, p6*).

"Initially, pharmacists should contact their PCT's pharmaceutical adviser to find out what the PCT's position is on LPS and whether they will be looking at bids now or later," said Georgina Craig, the NPA's head of NHS service development.

Ms Craig expects PCTs will discuss bids for LPS at their May board meetings. However, a decision will certainly be made before the June 28 deadline.

"It's a big step and pharmacists need to study the guidance before deciding if it's right for them," said Mike King, head of professional development and LPC services at the Pharmaceutical Services Negotiating Committee.

"Don't rush in just because you're dissatisfied with the existing contract," he warned. "Pharmacists must take a balanced view. Decide on what service you want to provide and in which vehicle. This could be LPS or as an add-on to the existing contract."

The dispensing element of LPS will be funded from the global sum and the add-on service locally by the PCT because it is a local service, said Mr King. "But the key thing is that the PCTs must find the money to fund LPS. There is no additional central funding unlike PMS [personal medical services]," he said.

Although the NPA says it is hard to predict how many pharmacists will be successful in having their proposals accepted i the first wave, it does want to hea from all cases where the PCT ha approved an outline proposal in principle. In such cases the NPA can offer tailored help in costing proposals, said Ms Craig.

The NPA warns that pharmacists should have adequat indemnity insurance in place before submitting LPS proposals

PRACTICE

Diabetes NSF standards for Wales

The National Assembly for Wales has published the standards for the diabetes National Service Framework in Wales. The 12 standards are based on those published in England in December but have been adapted for Wales.

The NAFW has made money available to help implement the standards. At the launch last week health and social services minister Jane Hutt said: "I have made £1 million available over the next two years for projects and pilot schemes associated with NSF standards."

FINANCE

Fraud savings announced

There have been savings of nearly £17 million due to action taken against pharmaceutical contractor fraud since the end of 1998.

Health minister Hazel Blears announced last week that savings made due to the prevention of continuing fraud were as follows:

Dec 98 - Mar 99	£ 52,882
Apr 99 - Mar 00	£2,103,119
Apr 00 - Mar 01	£3,189,111
Apr 01 - Mar 02	£3,972,342
Total	£9,317,454

Savings made as a result of cash recoveries were as follows:

Dec 98 - Mar 00	£2,251,815
Apr 00 - Mar 01	£3,097,676
Apr 01 - Feb 02	£2,130,260
Total	£7,479,751

Progress has been tracked since December 1998 when PSA targets on pharmaceutical fraud for the period to the end of 2001-02 were published.

- The National Audit Office has published the summarised accounts for the NHS in England 2000-01.

This included a section on fraud.

For more information:
www.nao.gov.uk

PRACTICE

Funding available for practice research

Community pharmacists looking to develop their practice research skills will be able to apply for bursaries from the Pharmacy Practice Research Trust.

The initial bursaries will support pharmacists who wish to undertake Masters level courses in subjects relevant to research in pharmacy practice, either clinical or health services.

Courses must include significant teaching relating to research methods and a period of supervised research leading to preparation of a thesis or dissertation. Subjects such as health economics, epidemiology, sociology and health psychology are considered particularly relevant.

The bursaries are only open to independent community pharmacists, locums or employees of a small chain (less than 60 stores).

Applications forms and guidance notes are available from Kerry Crabb, Medicines and People, c/o 1 Lambeth High Street, London SE1 7JN. Closing date for applications is June 14 and interviews will be held in July.

This month's Update question paper enclosed

Enclosed in this week's issue is the questionnaire (2231) for the following *Pharmacy Update* modules carried in April:

- Musculo-skeletal system (1231)
- Anxiety (1232)
- Hypertension (1233)

Pharmacy Update is a distan learning programme accredite by the College of Pharmacy Practice. Previous modules ca be accessed on the dotpharma website at: *www.dotpharmacy.com*.

Further information about enrolling for *Pharmacy Updat* is available from Mary Prebbl on 01732 2269.

The *Pharmacy Update* multiple choice questionnaire and telephone marking servic are supported by Genus Pharmaceuticals.

A collection of pharmacy antiques will be put up for sale next week in Lancashire. The entire contents of Bygone Times International, described as having been a leading supplier of architectural antiques and themed memorabilia, will be auctioned over three days from May 10-12. Among the pharmacy items on the block will be "dozens of antique chemists' bottles, two phrenology heads, a pair of brass beam scales and an antique counter top display cabinet". Other lots include a 1928 fire engine which is to be auctioned to raise money for the benefit of New York fire-fighters and their dependants. For further information or a catalogue, contact the auctioneers, shm Smith Hodgkinson, on 0161 233 2900, manchester@shm.co.uk or *www.shm.co.uk*

NORTHERN IRELAND

Community care plans are set to include medicines management

Northern Ireland's review of community care services has recommended the use of medicines management and greater involvement of community pharmacists.

The first report, published last week, says that "effective medicine management strategies should form an integral part of community care provision". Further, the Department of Health is committed to exploring the introduction of integrated management systems, "in particular the role of community pharmacists in community care". This is something that would best be done in conjunction with the planned Community Pharmacy Strategy, it says.

The report is the result of investigation into community care service provision in Northern Ireland commissioned last year. This first report concentrates on the hospital/community interface and services to older people. It provides a review of comments received, examples of good practice and recommendations for immediate and more strategic actions that should be taken.

Key recommendations relating to medicines management are that trusts should make use of the "vast body of research and local knowledge" in partnership with pharmacy colleagues. In particular, trusts are told to ensure that:

- community pharmacists are more involved in primary and community care systems
- the issues around medicines management are brought to the attention of all community staff involved in the care of older people
- a medicines review becomes a routine part of the care review process, especially for older people and those in residential and nursing settings
- education and training is provided to carers on the safe use and administration of medicines; and
- patients and/or carers receive written information and advice on their medicines before leaving hospital.

Consideration should also be given to increasing the current three-day discharge prescribing period.

Among the examples of good practice outlined in the report is the *Managing your medicines* medication review scheme delivered by community pharmacists. Launched in the winter of 2000-01, with a target of 20 per cent of pharmacies actively providing the service, the report says the recruitment target has since been exceeded. Although only a minority of contractors have actually commenced contractor reviews, "these early adopters have shown a high level of commitment and have been positive about the service, both in terms of the improvements in patient care and the professional awards".

Another example, that of a practice-based medication review carried out by pharmacists, found that savings resulting from the implementation of agreed therapeutic switches was cost effective, offsetting the employment costs of the pharmacists.

NPA to meet OFT

The National Pharmaceutical Association is to meet with the Office of Fair Trading on May 7 about its inquiry into pharmacy access.

The NPA will present a report which concludes that the current regulations have supported the community pharmacy network well, and have ensured that ready and easy access to NHS pharmaceutical services is available to everyone.

Society accounts available online

The Royal Pharmaceutical Society has published its full accounts on its website to allow members to inspect the figures in advance of the annual general meeting on May 15. A summary will be published in the Society's annual review 2001 being distributed to members this week.

For more information:
www.rpsgb.org.uk
Tel: 020 7572 2245.

OTC Guide correction

Day Nurse has recently been reformulated and no longer contains phenylephrine.

The *C&D Guide to OTC Medicines* 20th edition, published on April 13, lists the old formulation. The contents of Day Nurse Capsules are now: paracetamol 500mg, pseudoephedrine hydrochloride 30mg and pholcodine 5mg. Day Nurse Liquid contains the same ingredients in 15ml.

The smoking cessation product name on page 160 of the *Guide* is NiQuitin CQ Lozenges and not as published.

Five more on iCE

Another five accredited seminars have been added to the iCE online continuing education site on dotpharmacy (*www.dotpharmacy.com*).

The interactive seminars cover:

- oral contraception
- glaucoma
- anaphylaxis
- migraine
- the immune system.

There are now 19 hours of CPP-accredited seminars on the site. A further 11 hours will be added shortly. A certificate for an hour's continuing education is e-mailed to everyone who successfully completes the free demonstration seminar.

NPA to challenge sheriff over fatal accident

The National Pharmaceutical Association is planning a legal challenge to recommendations expressed by a sheriff in a Scottish fatal accident inquiry.

The sheriff was investigating the death of a terminally ill woman who died after being dispensed methotrexate although dexamethasone was prescribed (*C&D March 2, p9*).

In his findings, the sheriff noted that a dispensing error had taken place but added that one cause of this was the failure of the pharmacist to have "any system for checking whether any dispensing errors had been made".

He was particularly concerned that there was no procedure for reconciling at the end of each working day the record for drugs for which the pharmacy had received prescriptions and a record of the drugs actually dispensed. He thought that "in these days of modern technology" there should be IT systems available that could do this and recommended the pharmacy give urgent attention to installing such a system. However, the sheriff provided no indication of what the system might be.

The NPA is concerned that the sheriff's comments, which the NPA regards as "totally impracticable", have gone on the record and could impact on future incidents.

"If left unchallenged it could be construed that any pharmacy operating a dispensing procedure which did not involve reconciling prescriptions dispensed with medicines supplied was inadequate," it said on Tuesday.

At its meeting last week, the NPA Board also felt that the sheriff's recommendations would be too onerous to implement and would not in any case ever fully eliminate human error.

It has agreed that a request for a judicial review should be considered as otherwise the sheriff's comments could have ramifications not only for pharmacy practice in Scotland but across the UK.

However, if the legal challenge were successful, it would have the effect of quashing the sheriff's conclusions and ask him to reconsider what should be included in the inquiry findings, explained NPA chief executive John D'Arcy.

MEDICINES

P category here to stay

The Medicines Control Agency has confirmed it has no plans to remove the Pharmacy medicines category.

Health minister Lord Hunt said on Wednesday that he was not aware of any consideration to change the P classification. "There is an argument that it ensures safety – that is a good thing to move Prescription medicines on to being supervised by a pharmacist."

Dr June Raine, director of the MCA's post-licensing division, added: "It's staying that way. It's terribly important. There are no plans [for change]."

Lord Hunt: out to slash red tape

The minister was speaking at the signing of the first medicine (GlaxoSmithKline's Flixonase) to be switched from POM to P under the new system for reclassifying medicines.

"We are launching a very important strategy which is about getting wider access to medicines for the general public by slashing the red tape," said Lord Hunt. The new system will approximately halve the time taken to reclassify medicines.

Although Lord Hunt thought that a three-month exclusive marketing agreement post-reclassification would be an incentive for more switches, GSK's Simon Pulsford was concerned that this may not be long enough for off-patent products. However, the shortened approval time was "a big benefit".

PAGB director Sheila Kelly pointed out that the provision of professional training and patient information was a key factor in the reclassification process.

Mr Pulsford agreed, arguing that the P category was strengthened under the new system: "It underlines the importance of the P category as it enables us to bring products to market with the pharmacist's supervision."

POLITICS

MPs call to fund pharmacists' training

A parliamentary group is calling on the Government to fund locum cover for self-employed pharmacists to continue their training in dermatology.

In its latest report, which looked at primary care dermatology services, the Associate Parliamentary Group on Skin (APGS) also says the Government should become more involved in the training of pharmacists, nurses and doctors in a bid to increase the quality of training in dermatology.

The report recommends the implementation of a proper structure for funded study-leave as "self-employed pharmacists and single-handed pharmacist managers find it difficult to take time off during the working day".

For chronic skin conditions, the APGS would like to see: appropriately trained pharmacists given authority to fill repeat prescriptions; vary prescriptions within certain categories of treatment to enable patients to find medicines that suit them best; and prescribe such treatment themselves.

Questiontime

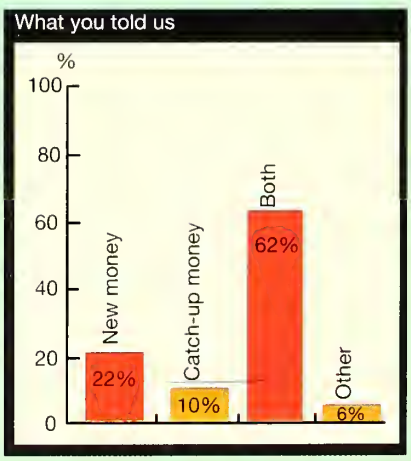
in association with UniChem

Last week we asked you: On which basis should pharmacists make a claim for part of the NHS's extra £40bn as announced in the Budget? While 22 per cent said negotiators should push for money for new roles, and 10 per cent wanted 'catch-up' money for dispensing, 62 per cent wanted both (see right).

This week's question: Four months in, how would you rate +Plus, GSK's new trading scheme, compared to the old agency scheme?

Like it – terms much better · Marginal improvement · Much the same · Not quite as good · Much worse off

You can record your vote on our website: *www.dotpharmacy.com* Question time appears on the home page. Select your answer and then click on the "vote" box. Your answer is automatically collated. You have until noon on May 7 to cast your vote. We will publish the results in *C&D*, May 11.




The Complete Treat feet
have been waiting for
Footcare is big business - and now, there's a completely new range of products for feet to feel good about. New Footeeze from Lanes is the first ever range of natural foot care products to warm, soothe, revive and refresh feet. With its striking 'Don't forget your feet' consumer advertising campaign, Footeeze is just what your customers have been waiting for.
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• Made with natural ingredients
• Lanolin Free
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For more information and POS materials, call 01452 507548
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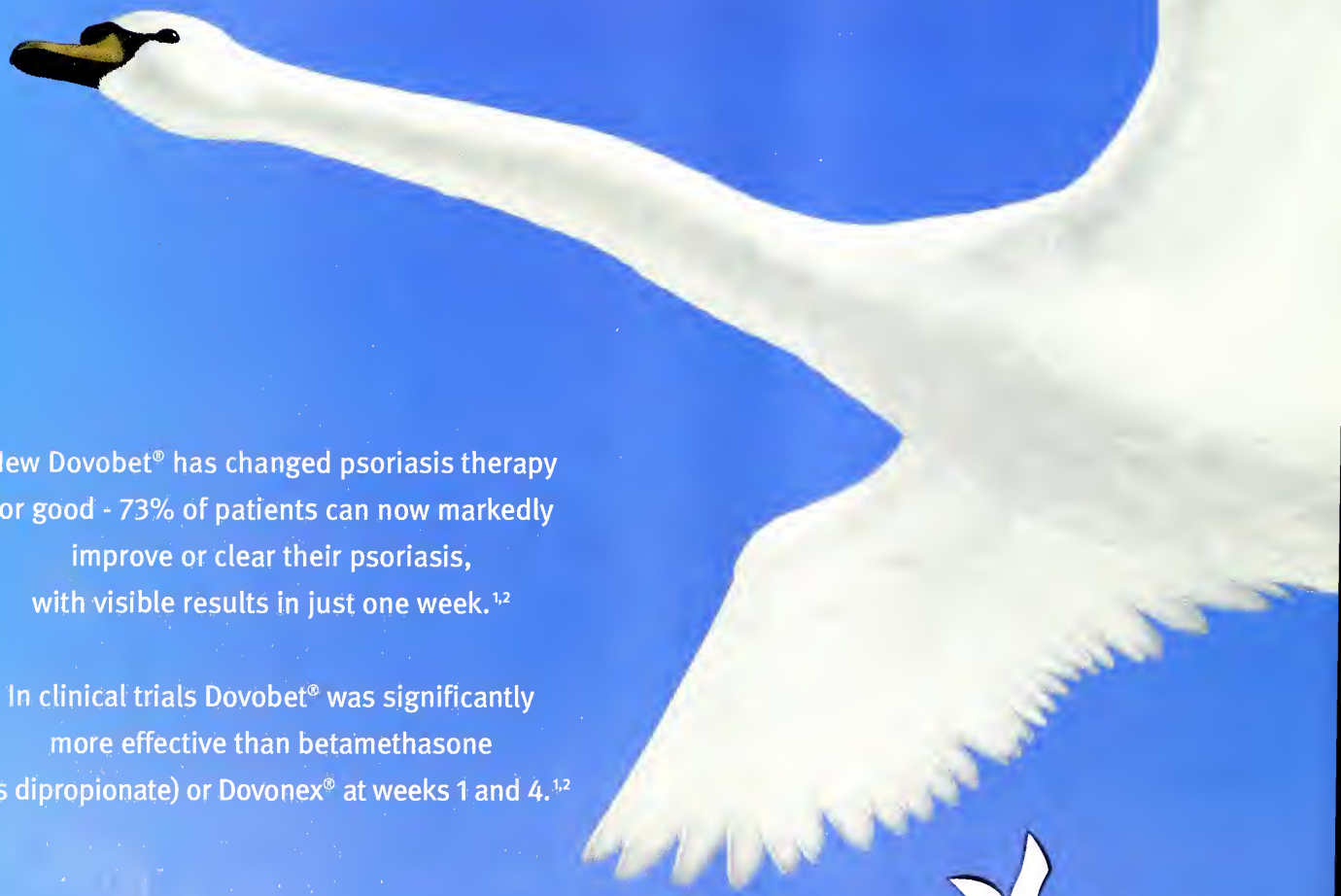

New Dovobet® has changed psoriasis therapy for good - 73% of patients can now markedly improve or clear their psoriasis, with visible results in just one week.[1,2]

In clinical trials Dovobet® was significantly more effective than betamethasone (as dipropionate) or Dovonex® at weeks 1 and 4.[1,2]

NEW Dovobet®▼
calcipotriol / betamethasone dipropionate

New Dovobet® - Fast, effective, first-line therapy in psoriasis.

Abbreviated Prescribing Information for Dovobet® 50 microgram/g + 0.5 mg/g Ointment. **Indications:** Treatment of stable plaque psoriasis vulgaris amenable to topical therapy. **Active Ingredients:** 50 µg/g calcipotriol (as hydrate) and 500 µg/g betamethasone (as dipropionate). **Dosage and Administration:** Apply twice daily not exceeding 4 weeks. Maximum dose should not exceed 15g/day. Maximum dose should not exceed 100g/week. Treated area should not be more than 30% of body surface. No experience of use for longer than 4 weeks or of repeated use. No recommendation for use in people under 18 years. **Contra-Indications:** Hypersensitivity to any constituents. Patients with known calcium metabolism disorders. Viral skin lesions, fungal or bacterial skin infections, parasitic infections, skin manifestations in relation to tuberculosis or syphilis, rosacea, perioral dermatitis, acne vulgaris, atrophic skin, striae atrophicae, fragility of skin veins, ichthyosis, acne rosacea, infected wounds, perianal and genital pruritus. Guttate, erythrodermic or exfoliative, pustular psoriasis. Severe renal insufficiency [illegible] disorders. **Precautions and Warnings:** Avoid inadvertent transfer to scalp, face, mouth and eyes. Wash hands after applying. Avoid concurrent treatment with other steroids. Adrenocortical suppression or impact on the metabolic control of diabetes mellitus may occur. Avoid application on large areas of damaged skin, under occlusive dressings or on mucous membranes or skin folds. There may be a risk of generalised pustular psoriasis. No experience of use on scalp. No experience of concurrent use with other antipsoriatic products or phototherapy. **Use in Pregnancy and Lactation:** Only use in pregnancy when potential benefit justifies potential risks. Caution when prescribed for women who breast feed. Instruct patient not to use on breast when breast-feeding. **Side Effects:** Pruritus, rash, folliculitis. Undesirable effects observed for calcipotriol and betamethasone. Calcipotriol: transient local irritation, dermatitis, pruritus, erythema, aggravation of psoriasis, photosensitivity, hypersensitivity reactions including very rare cases of angioedema and facial oedema. Hypercalcaemia or hypercalciuria may appear very rarely. Betamethasone: local reactions, especially during prolonged application including skin atrophy, telangiectasia, striae, folliculitis, hypertrichosis, perioral dermatitis, allergic contact dermatitis, depigmentation, increase of intra-ocular pressure, cataract, colloid milia, generalised pustular psoriasis. Systemic effects occur more frequently when applied under occlusion, to large areas and long term treatment. **Legal Category:** POM. **Product Licence Number and Holder:** 05293/0003. LEO Pharmaceutical Products, Ballerup, Denmark. **Basic NHS Price:** £55.00/120g. **Date of Preparation:** May 2002. **References:** 1. Douglas WS et al. Poster presented at EADV 2001, Munich, Germany. 2. Data on file, LEO Pharmaceuticals.

Full Information is available from:
LEO Pharmaceuticals, Longwick Road,
Princes Risborough,
Buckinghamshire, HP27 9RR.
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e-mail: Dovobet.UKenquiries@leo-pharma.com

L E

SCOTLAND

Bigger primary care role for Scottish pharmacists

A bigger role for pharmacists in prescribing and managing chronic disease is expected next year, according to the Scottish health minister Malcolm Chisholm.

"We aim to maximise the expertise of pharmacists who, of all health professionals, have the widest knowledge of the science and use of medicines," he said at a Scottish Parliament debate on modernising primary healthcare last Thursday.

Mr Chisholm is pushing for primary care teams, including pharmacists, to drive NHS reforms.

"We intend to back local primary care teams in taking a central role in leading reform in the NHS. Those professionals - GPs, nurses, pharmacists, dentists, health visitors and others - see patients most often and know best their needs. They must be the leaders of change who drive forward the development of care and the redesign of services around the needs of patients," he said.

Mr Chisholm further backed the case for primary care teams by saying that he did not support local healthcare co-operatives (LHCC) holding funds for commissioning secondary care, believing it would set up "unnecessary bureaucracy.

"A distinction must be made between primary care teams and LHCCs," added deputy health minister Hugh Henry. "We are clear that we are not talking about transferring commissioning powers to LHCCs. We want to empower primary care teams. The aim is to devolve power to LHCCs to support and empower primary care teams," he added.

In his speech, Mr Chisholm also backed the recommendations made by the Scottish Primary Care Modernisation Group in its report, *Making the Connections*, which called for integrated working between pharmacists and GPs along with a need to review the role of community pharmacists *(C&D, March 30, p4)*.

"There will be a major drive to encourage collaboration in primary care, for example by funding more locum covers" so that healthcare professionals could share best practice, said Mr Chisholm.

"Within the next year, I expect real and tangible progress in three key areas: NHS24, a bigger role for pharmacists and nurses in prescribing and managing chronic disease, and developing the role of 'health improvement champions' in every local community," he said.

For more information:
www.scottish.parliament.uk

The Royal Pharmaceutical Society's Welsh Executive held its annual dinner at the St David's Hotel, Cardiff. Ann Lloyd, director of NHS Wales, was the guest speaker. Pictured left to right are: Carwen Wynne-Howells, chief pharmaceutical officer for Wales; David Temple, director of postgraduate pharmaceutical studies for Wales; Ann Lloyd; Andrea Robinson, chairman of the Welsh executive; Alison Strath, chairman of the Royal Pharmaceutical Society's Scottish executive and Bill Scott, chief pharmaceutical officer for Scotland

POLITICS

PCT execs criticised for GP bias

PCT executives have come under attack for shutting out pharmacists from their plans to expand spending on health from the Budget.

The National Pharmaceutical Association's head of professional development, Georgina Craig, said that when the PCGs started they attracted GPs who felt it could make a difference in their community, while many of the "more political" GPs stood back and waited. But when the PCTs were started and they saw real power would be devolved to them, the GPs stood for key posts on PCT executives. The result, she said, was that the PCTs were against taking innovative decisions.

Ms Craig was speaking at the launch of a public health policy report by the parliamentary All-Party Group on primary care chaired by Howard Stoate, a GP and Labour MP.

A member of the NPA board had told her that his own PCT executive was looking at recommendations to spend an extra £100,000 on primary care.

"The conversation was about 'how can we keep this in surgeries'," she told MPs. "That is not going to help public health because you want to keep people out of surgeries, not in them. If that is indicative of the kind of conversations going on around PCTs, we have a real problem because no change is going to happen."

LEGAL

SPUC loses bid to appeal

The Society for the Protection of Unborn Children (SPUC) has been denied leave to appeal in its challenge to the sale of the morning-after pill and must pay all court costs.

"We are disappointed with the decision. The issues were of the utmost importance for women and the unborn child," said Paul Tully, SPUC's general secretary.

"We will now consider seeking permission to appeal directly to the court of appeal."

This follows last month's ruling where the High Court rejected a bid by SPUC to prevent such sales *(C&D, April 27, p6)*.

SPUC must now pay the Government's legal costs and those of Schering Health Care, the manufacturer of Levonelle.

PRACTICE

Latest Wellard's published

The fifth edition of Wellard's *Guide to the NHS and Medicines* is now available. All sections have been revised in line with changes taking place within the NHS, including the emergence of medicines management and PCOs, as well as more policy coverage of NSFs.

The main chapter headings include the new NHS structure, NHS boards and management, staff and physical resources, finance, NHS information, law, and the history of the NHS.

Copies cost £38.95 and are available from JMH Publishing Ltd, Bramblebank, Turners Green Road, Wadhurst, East Sussex TN5 6EA. Tel: 01892 546446. *E-mail: john-heath @jmh-publishing.co.uk.*

Supervision and skill mix debate

The National Pharmaceutical Association Board has agreed that there is an "urgent need" to continue to engage the Royal Pharmaceutical Society and its own members in the discussions about pharmacy supervision and skill mix.

"There is a need for a full debate on supervision and skill mix in the community pharmacy to ensure that a modern approach to supervision is adopted which best meets the needs of patients and assures patient safety," it said on Tuesday.

Seeking to clarify its own position, the NPA explained that it fully supports the view that ways must be found to free up pharmacists' time from the mechanical aspects of dispensing towards a more cognitive role.

This would include having appropriately qualified and trained staff available and taking into account changing pharmacy practice and new technologies.

However, the Board was "adamant that this should not mean that pharmacists could delegate totally the pharmaceutical assessment of each prescription to support staff.

"Instead they agreed that there was still a need for every prescription to be clinically assessed by a pharmacist at some point, but the rest of the dispensing process could then be delegated to properly trained support staff so as to free up the pharmacist's time for other patient-focused roles."

The Board also takes the view that "within the current interpretation of supervision there was considerable scope for pharmacists to adjust their ways of working to free up time spent on the mechanical aspects of dispensing to spend more time where they were most needed – with patients and customers".

Standard operating procedures for dispensing are expected from the Society and the NPA is preparing a resource pack for members in anticipation.

C&D

Still time to excel in business

There is still time to enrol on the *C&D* Pharmacy Business Excellence course sponsored by Crookes Healthcare.

Pharmacists who register now can obtain four and a half hours of accredited continuing education and be in with a chance to win £2,500 in the Crookes Business Person of the Year competition. The three-part course contains modules on merchandising and stock management, marketing your pharmacy and selling skills.

Any of the three modules and additional copies can be obtained from Crookes Healthcare on 0115 953 9922, or from the Crookes website *www.crookes.co.uk*. Module 1 contains a course registration form. The telephone marking line remains open until the end of May.

Mawdsleys signs first rugby sponsorship deal

The independent wholesaler Mawdsleys has signed its first ever sports sponsorship deal with Rugby Superleague Club Salford City Reds. The club's under 17s team will be sporting the Mawdsleys logo on their shirts during the coming season.

Integral to the deal is the election of a "player of the month". With many of the team's members still in full-time education, the emphasis is clearly on raising the sport's profile in secondary schools in the Greater Manchester area. A £50 cheque will be presented to the winning player at his school.

Left to right: Philip Bradley (Mawdsleys' marketing manager), team members Keiron Hersnip and John Clough, coach Mark Lee, Paul McAllister (Mawdsleys' sales manager) and team member Mark Stevens

FINANCE

Better banking services expected

Pharmacies and other small businesses can expect to get a much better service from high street banks after years of being overcharged.

A recent Competition Commission report claimed that the big four banks - HSBC, Lloyds TSB, Barclays and Royal Bank of Scotland (including NatWest) - had grabbed £2.2 billion in unnecessary charges from small businesses.

The report corroborates the findings of bank charge auditor ABA, which successfully reclaimed £6,000 for a Bolton pharmacist (*C&D April 27, p10*).

Independent pharmacists should see some financial benefits fairly soon as the Office of Fair Trading's director general will be asking the major banks to offer small and medium-sized businesses (SMEs):

- an account that pays interest of around 2.5 per cent lower than the Bank of England base rate or
- a current account free of money transmission charges or
- a choice between the two.

These are short-term measures designed to provide SMEs with some relief while the OFT and the banks continue to negotiate how to improve the SME banking structure.

Endorsed by the Government, the report said the eight main clearing banks operated in a way that distorted and restricted competition. For example, SMEs needed to hold a current account before a bank would offer them a loan or deposit account negotiations. Discounts were only offered to selected customers.

Following Government advice, the OFT has made 13 proposals to improve the service high street banks offer. For example, the banks will have to compile and publish information about their standard tariff prices for transmitting money, and the interest paid on current and short term deposit accounts.

Eventually SMEs should find it easier to switch banks, whose charges will be lower and more transparent. There will also be a greater choice of services both within and between the various banks.

PRACTICE

Consumers at risk from rogue online pharmacy

Hundreds of online pharmacies are breaking the law by selling prescription drugs to consumers in the UK and elsewhere, according an internet monitoring company.

Cambridge-based Envisional said consumers were risking their health by taking prescription drugs without proper medical supervision. And pharmaceutical companies face potential legal repercussions if their products are sold through unregulated websites.

Envisional's research suggests that many sites will deliver drugs such as Viagra, Propecia and Xenical direct to consumers without prescription. Performance-enhancing drugs are also readily available.

While the Medicines Control Agency has persuaded a few offending companies to amend their websites to reflect the UK law, it admits hundreds of others continue to operate.

Clare Griffiths, a lawyer at London-based law firm Briffa, said not much could be done if the online pharmacists are based outside the UK. But UK regulatory authorities and the police, she claims, have not been able to clamp down effectively on illegal online pharmacies in the UK.

"Without specific legislation or licensing of e-pharmacies, genuine sites are concerned that patients may unwittingly purchase their medicines from 'cowboy' sites," she said.

One solution is to enforce trademark rights against any sites that brand themselves as online pharmacies, or use domain names in a confusing way.

The UK Government, she added, should co-operate with other governments to clamp down on the illegal sites. But she admitted that the process would be an uphill struggle. A year ago the Clinton Administration had little success in getting governments to co-operate on closing down illegal online pharmacies, even when it highlighted the domain names and addresses.

Meanwhile, pharmaceutical companies who knowingly supply drugs to such sites "would be liable for any foreseeable personal injury, including death from misuse. I know that the Association of the British Pharmaceutical Industry is keen to be seen to be squeaky clean on this issue, but any slip-up could have significant consequences."

WHOLESALERS

Sants acquires Wardles

Regional wholesaler Sants Pharmaceutical distribution has acquired Donald Wardle & Son, the distributor of surgical appliances and niche pharmaceuticals, for an undisclosed sum.

Apart from its core business, Wardles also operates a retail outlet and a hearing aid centre, both of which are located in Stoke-on-Trent. The company has annual turnovers of £1.4 million.

Sants, a subsidiary of United Co-op, has retained the current management team and said that it did not anticipate any major changes in the immediate future.

Wardles' three warehouses in Stoke, Birmingham and Stroud will remain open and could potentially form the basis for future expansion.

Stephen Smith, managing director of Sants, said the acquisition was a significant step in developing a strong competitive approach to further healthcare sectors, such as hearing and disability aids.

Sailesh Dawda from Theydon Bois Pharmacy in Epping, pictured with Andrew Sollitt, Numark's marketing director, has become Numark's 1,500th shareholder

MULTIPLES

NCC beats the odds

National Co-operative Chemists' trading surplus rose a fraction to £7.4 million last year, while its turnover was up 10.7 per cent to £193m.

NCC said it had done well to increase its surplus amidst a climate of falling remuneration and inflationary pressure on pharmacists' salaries. Last year it spent an extra £800,000 on these salaries – equivalent to a 7 per cent increase.

Meanwhile, NCC's dispensing sales rose 12.3 per cent to £150m, while its OTC business grew 5.7 per cent to £42.7m. It lost a few sales to supermarkets, and its margins dipped slightly following the abolition of Resale Price Maintenance. But the chain countered by running two promotions for a range of well know brands during the year.

NCC has begun an EPoS trial at 10 stores.

ONLINE

Revamped website

Nucare has re-launched its website, *www.nucare.co.uk*, giving it a more contemporary, up-to-date feel. Mainly aimed at existing and potential members, the site provides information about the buying and marketing group, the services provided by Nucare as well as promoting Nucare's own-label product range.

TRAINING

Lloyds' management training drive

Lloydspharmacy has launched a four-part professional management development programme designed to support the learning of its pharmacy managers.

Available from the company's pharmacy managers, the distance learning programme consists of four modules: Our People, Our Business Performance, Our Customers and Our Pharmacies, Services and Products.

Covering key managerial skills, business management techniques and background on key challenges for pharmacists (ie the NHS Plan, clinical governance, medicine management), each of the modules includes exercises and case studies.

Coming Events

MAY 9
NICPPET,
CPD – putting theory into practice, NICPPET Resource Centre, School of Pharmacy, Belfast, 7pm to 10pm.

MAY 10
NICPPET,
Patient Group Directions, Fitzwilliam International Hotel, Antrim, 10am to 5pm

Comment from the Editor

At the 11th hour guidance for LPS has finally emerged from the Department of Health. Fortunately, bearing in mind the June 28 deadline for PCTs to receive bids, there are no surprises. Interpreting the guidance and extrapolating its implications is a major task in itself, and while that may deter some, there is a lot of interest in LPS.

What happens next is anyone's guess. Will independents risk giving up the security of the dispensing fees from their 4,500 odd items a month? There is the preferential return ticket, but to what? Will multiples deluge PCTs with bids on the assumption that some will be accepted? Will other industry players see this as a route to elbow their way into direct service provision?

While the scope of services that might be provided under LPS is broadly defined by the NHS plan, in practical terms it is a blank page. It provides an opportunity for pharmacists to re-engineer the services they provide and design a contract of their choosing. The DoH wants to see innovation because it wants to find ways of moving away from the current contract.

And who knows how many bids will actually be accepted? That will be down to PCTs. There is no new funding for services, although there has been some development money. Pharmacists have to be grown up and realise they need to make a good business case to get plugged into mainstream NHS funding. That said, there is a healthy degree of scepticism over whether GP-dominated PCTs will be able to think outside their own self-interested box, despite "encouragement" from the DoH in the shape of a warning that they could face judicial challenge if they do not properly consider bids. So while LPS is exciting, it will not be for everyone, and like much else in the NHS, there is an element of the postcode lottery.

The DoH wants to see innovation because it wants to find ways of moving away from the current contract

Yourviews

Professor Ronald Purkiss, clinical director at Sheffield Teaching Hospitals, welcomes the Audit Commission report, but says it is flawed

Spoonful of sugar is short of a full measure

The recent Audit Commission on medicines management in NHS hospitals seeks to:

- raise awareness of medications management at NHS Trust boards
- collect baseline data on the management of medicines
- link medication management to clinical governance and risk management
- provide a basis for the improvement of medicines management via the audit and performance management.

The report asked one basic question: does the Trust provide an effective medicines management service? and five supplementaries:

- is there effective control over medicines expenditure?
- is staffing adequate for the service that should be provided?
- is the use of pharmacy staff cost effective?
- do staff devote enough time to direct patient care?
- has the service introduced processes in line with accepted good practice?

To answer these questions the Commission sent each acute Trust a self-audit questionnaire asking for basic data on the services provided, the extent of those services, medicines expenditure and staff utilisation.

To compile the report, many assumptions were made about service provision, comparable measures of effectiveness, what were good and bad practices and use of staff time.

For instance, the measure used to see if pharmacy staffing is adequate was the ratio of finished consultant episodes (FCEs) to the whole-time equivalent (WTE) number of pharmacists and technicians in post. No evidence exists that FCEs are an effective measure of pharmacy workload.

Professor Ronald Purkiss: despite limitations, the report is welcome

The report makes 33 recommendations, many of which are not based upon the data collected, but on selected literature, or what seems to be the advice of external advisors or organisations.

Little in the recommendatio would be disputed by hospital pharmacists, but whether the organisations charged with implementing them can or wil deliver is debatable.

The Royal Pharmaceutical Society is cited as being responsible for one highly political recommendation (registration of pharmacy technicians) and one it cannot necessarily deliver – professio competence and performance surely down to employers?

In spite of limitations, any Commission report must be welcomed. Discussion and feedback are needed on the assumptions and modificatio ensure medication manageme moves forward in a fair mann

Northern Ireland NOTEBOOK

What about negotiation?

The analysis of the Chancellor's Budget and the promised financial support to the NHS has been extensive. The professional press has been plentiful in its suggestions of what pharmacy might hope to gain.

It is accepted that many NHS staff will join the gravy train, with nurses the first to state that an additional 10 per cent on their salaries is needed immediately.

PSNC suggests that, for the UK to get the pharmacy service it deserves, an additional 50 per cent needs to be added to the global sum. Possibly, but then what is the pharmacy service PSNC is talking about?

National pharmacy plans for both England and Scotland define the service the public will get. Northern Ireland has yet to see its pharmacy strategy, if there is one. Nonetheless, pharmacy must deliver against these strategies and those who do will be rewarded.

... an additional 50 per cent needs to be added to the global sum

I am impressed by what I know about the Scottish and English pharmacy plans. That said, I can't help but feel that, as a profession, we are simply amateurs when it comes to dealing with DHSSPS. The Department will get what it wants. Sadly, we do not negotiate, we simply debate and, worse, fail to appreciate what negotiation is.

The DHSSPS produces its plans – which we are happy to wait for – and we criticise. We usually end up with what was initially suggested or what the Department felt it could allow us.

This is not negotiation. Negotiation is where both parties work together and seek to find a common solution to a shared problem. What input has the profession had to the N Ireland Pharmacy Strategy?

Written by a practising Northern Ireland community pharmacist

TOPICAL REFLECTIONS

I'm still getting my head around LPS

I have often said I am confused about local pharmaceutical services and their impact on my business and practice. That confusion has been partially clarified by some detailed explanations of common questions asked of the National Pharmaceutical Association (*C&D April 27, p37*). My thanks to the NPA but, as the mists begin to clear, so I become more concerned.

Is LPS a genuine opportunity or a deliberately complex scheme designed to provide improved pharmaceutical services at my expense? LPS could potentially revolutionise the practice of community pharmacy but, equally, could decimate the equity value of many pharmacy businesses. An essential element to an LPS pilot is the dispensing of medicines for an identified patient group, where the total dispensing fees are contracted by estimate rather then being paid as an item of service.

I agree that if the estimated prescription numbers fall, then the difference will effectively be paid for by the PCT – once to the contracted LPS and once to the actual source of the dispensing. But, in reality, I would expect dispensing items to rise as a result of the added value of the LPS provided and the public, not restricted by patient registration, to vote with their feet.

LPS contracts are, therefore, an opportunity to expand services but also a threat to pharmacy contractors if they choose to become involved in competitive tenders for extra services, or see their prescription numbers and their income fall (since we are all still working under the old contract). This is a complex agenda and perhaps gives a clue to the reasons why the DoH has been prevaricating over a new contract, and the unseemly haste of a June 2002 deadline for first wave pilot proposals. LPS competition will be that much more effective in providing extra services funded from the existing global sum while the old contract exists.

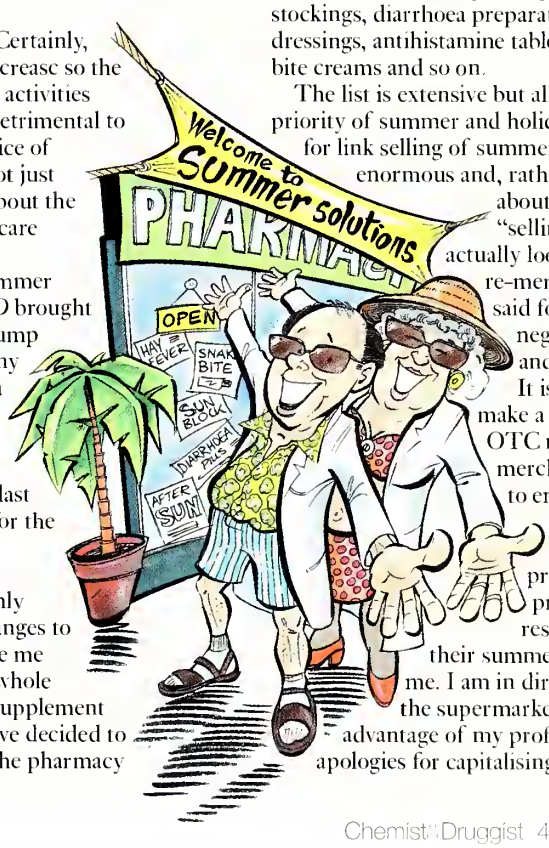
The opportunity is there to identify new services that address local need and attract extra funding from external sources. PCTs will look most favourably on those proposals that limit their financial commitment. Maximum gain for minimal cost will be the determining criteria and, if existing contractors suffer, that's competition for you.

Time to profit from summer health

I sometimes think the NHS and its problems dominate my thoughts in a disproportionate manner. Certainly, as prescription numbers increase so the time I devote to front shop activities decreases and this can be detrimental to my business. But the practice of community pharmacy is not just about the NHS, it is also about the private provision of healthcare funded from OTC sales.

Last week's excellent summer health supplement in *C&D* brought me down to earth with a bump because it identified so many sales opportunities and at a time when the thought of summer and hay fever had hardly entered my head. But it is now May and my last chance to effectively plan for the summer season.

In my pharmacy antihistamines are still firmly behind the counter but changes to GSL availability have made me think I should change my whole approach. I have read the supplement from cover to cover and have decided to devote a whole section of the pharmacy to summer marketing. Sun protection creams, travel stockings, diarrhoea preparations, first aid dressings, antihistamine tablets, insect repellents, bite creams and so on.



The list is extensive but all linked by that one priority of summer and holidays. The opportunity for link selling of summer preparations is enormous and, rather than feeling guilty about those nasty words "selling" and "profit", I am actually looking forward to a bit of re-merchandising. Dotty has said for a long time that I am neglecting the front shop, and she is right.

It is not unprofessional to make a living from selling OTC medicines or from merchandising attractively to encourage link purchases. My customers expect me to provide good, sound professional advice and respond by purchasing their summer requirements from me. I am in direct competition with the supermarkets but have the advantage of my profession. I make no apologies for capitalising on that advantage.

UCA Conference

The Ulster Chemists Association conference, held a fortnight ago near Enniskillen, Co Fermanagh, was themed around medicines management

UCA president Siobhan O'Reilly (above right) with her brother, Philip Reilly, Professor of General Practice at Queen's University of Belfast, who spoke about prescribing competencies

Coming your way soon...

One of the targets of Northern Ireland's Health & Social Services programme during 2002/03 is delivery of medicines management schemes through 30 per cent of pharmacies.

Pharmacists are well placed to deliver what is required, Siobhan O'Reilly, UCA president, told the conference. *Investing for Health*, a DHSSPS report, estimates that 160,000 people visit Northern Ireland's pharmacies daily; eight out of 10 use the same pharmacy; and 93 per cent of people welcome greater pharmacist involvement in health promotion.

"Proper reward must be ensured for these quality driven value added services," she said.

Medicines account for 15 per cent of NHS spend, but up to 50 per cent of people use medicines in a way which is not fully effective, said National Pharmaceutical chief executive John D'Arcy.

Around £100 million of medicines are returned to pharmacies annually, and medicine-related problems are the cause of 5-7 per cent of hospital admissions.

"Pharmacists' solution to these problems is medicines management," he said, "but it is not your exclusive domain, or doctors' or nurses. And if we take it on we cannot put the blinkers on. We will need to find partners."

The pharmacy network provides easy access to healthcare for patients and the NHS wants to build on it, said Mr D'Arcy. At the same time the Office of Fair Trading is looking at access to pharmacy services. This is not joined up thinking, he said.

Any change in the control of entry regulations will be seized on by the multiples. It could make health management services difficult to deliver.

The price of negligence

Medical negligence is a growth industry. Between 1998-2001 the cost of healthcare litigation for the 1.6 million people in N Ireland was £27 million, said Rosemary Wilson, a clinical barrister.

The NHS faced a bill of £2.3 billion in 1998 for medical negligence. Figures released last week by the National Audit Office show it has risen to £4.4bn in 2001.

The cost is a severe drain on healthcare budgets. Yet only three out of 10 potential cases actually sue, and 97 per cent of cases settle out of court.

"If a case goes to court very few patients win. The onus of proof is on the patient, who has to prove you have been negligent," said Ms Wilson. "People only go to court if they can afford to lose."

Legal accountability is the same whether you are a pharmacist, a GP or a nurse. "You are answerable in law for all your actions and omissions, all the advice you give or do not give, and all the things you write down or don't write, while fulfilling your role as a pharmacist."

And 80 per cent of litigation

Clinical barrister Rosemary Wilson (right): You are answerable for all your actions and omissions – around 80 per cent of litigation revolves around omissions in care

revolves around omissions in care. "Collecting records on your computer is fine, but your Code of Ethics requires you to record other things too," she cautioned.

For negligence to be proved, three criteria have to be satisfied:

- the duty of care owed by the defendant to the plaintiff has been breached. A duty of care arises where there is a "close and proximate relationship" between the patient and pharmacist
- there has been a breach of the standard of care owed to the plaintiff. The court will ask what standard is expected and did the pharmacist achieve that standard?

The court may take the view of an expert witness about what a professionally competent pharmacist would have done.

A pharmacist need not possess the highest expert skills at the risk of being found negligent. It is well established in law that it is sufficient if he exercises the ordinary skills of a pharmacist practising his profession.

"But standards change as knowledge develops and pharmacists are expected to keep up to date, said Ms Wilson. "Principle 5 of the PSNI's Code of Ethics requires a pharmacist to keep abreast of the progress of pharmaceutical knowledge in order to maintain a high standard of professional competence."

- The breach has caused foreseeable harm. Causation has to be proved, and how "remote" the pharmacist is from the damage will be considered.

Pharmacists owe a duty of confidentiality to their patients. "That duty is not absolute, but b very sure about what you are doing if you decide to breach it," she advised. Principle 4 of the PNSI Code of Ethics says there should be no disclosure without consent, or in the client's or public interest.

Article 8 of the Human Rights Act 1998 talks about a "right to privacy". Patients now have a statutory right, which has tightened rules on confidentialit

"You need to be wary about documentation. You are legally accountable for everything you write/record or don't write/record. It is not a thing you should do when you have the time, you should build it into yo practice," Ms Wilson advised.

"Quite often it is not that you have given good care, but that yo do not have a record of it. A dut of care applies to knowledge and recording it appropriately."

The future is present

Modernisation of pharmacy practice is happening more rapidly in Northern Ireland than anywhere else in the UK. "But in typical fashion we are resistant to change and suspicious of others' vision. This attitude is a major barrier, if not *the* major barrier, to progress," according to Belfast pharmacist Dr Terry Maguire.

He called for a pharmacy strategy from the Department of Health "that the profession is fully part of developing". There is no need to start from scratch as it is already there in *Vision 2020*, the strategy paper from the Pharmaceutical Society of Northern Ireland, he said. "We simply need to stuff it full of DHSSPS jargon."

New Labour is committed to achieving excellence through clinical governance. A paper, *Best Practice Best Care*, due to be published soon, will bring the concept into practice in Northern Ireland.

"Quality is about standards, and more importantly, it is about attitudes. It is about the standards we feel are fit for the businesses we run and the services we provide," said Dr Maguire. PSNI is supporting standard setting and there will soon be a requirement for standard operating procedures for dispensaries.

Local health and social care groups will take on the responsibility of looking after the health of the population. Although experimental, they are powerful because they will commission services and spend the money.

"We've done well in N Ireland to have one pharmacist on LHSCGs as of right, and possibly more," said Dr Maguire.

For the NHS of the future, the good news is that what pharmacy needs to offer, and what will be bought by the Health Service, is nothing that has not been discussed for 20 years, he said. What the NHS will buy is:

- health promotion services
- prescribing for minor ailments
- medicines management.

"Remember it is not what we want the DHSSPS to give us; it is what they are willing to buy from us. There are other providers and as in any market they may be chosen," he warned.

To make more time available for new roles non-pharmacists must be much more involved in the mechanics or operational aspects of dispensing.

"Pharmacists must retain and further develop their clinical responsibility for dispensing," he said, "but more steps need to be taken by the PSNI to ensure that all pharmacists are supported in making use of technicians. Hospital pharmacy has got it right with checking technicians."

Pharmacists are highly efficient at processing "an unreasonable number of prescriptions with very few errors". The NHS could not hope to create a more efficient medicines supply system, argued Dr Maguire. But the contract is seriously flawed, he said.

"Work has started on a new contract for England that will have a significant impact on us. What surprises me is that rather than pre-empt this and come up with a shopping list of our own, the PCC will wait in its usual fashion to react aggressively to any proposal that will eventually come from the DHSSPS."

He said the additional costs to provide new services from community pharmacies would require, at minimum, a 33 per cent increase in the global sum.

Medicines management pilots in England are producing tensions which could potentially split the profession into those who opt to provide only a supply service and those who provide medicines management.

Dr Terry Maguire: "I hope we avoid a typical English fudge"

Prescribing advisers have been developing their role for over a decade and have become clinical pharmacists in primary care.

"From the outset in England we will see a twin approach to services: those provided from community pharmacies and those provided by prescribing advisers within GP surgeries.

"There will be a need to decide which of these models wins through - or is there room for both?" asked Dr Maguire. "There is insufficient funding to go both ways. I hope we avoid a typical English fudge."

For contractors the current developments are dangerous and the negotiating bodies must assert themselves to check the ambitions of prescribing advisers.

"This should be a constructive discussion. Prescribing advisers have become an effective and highly professional group. They are also politically aware and know more about using the Health Service to their advantage than contractors.

"They will and should remain, but their role should be strategic and supportive, with community pharmacists taking on the operational aspects of medicines management."

BGMA threatens push for generic substitution

If the major drug companies continue to erode access to market for generic manufacturers then the UK's generics industry will start to lobby for generic substitution.

John Beighton, chairman of the British Generic Manufacturers Association, said: "We have not felt the need to move on this before, but if industry continues to erode our access to market, it may be something that we would push for, possibly with pharmacists' support."

For generic manufacturers, being able to develop markets for drugs which come off patent is critical.

Mr Beighton highlighted two ways in which his industry was being "gently squeezed" to make it more difficult to bring generics to the market:

- data exclusivity, where manufacturers are granted a period of exclusivity on top of the original patent when a product's indications are extended
- withdrawal of a product before patent expiry, and then bringing out a very similar line (such as an isomeric version) with the same indications.

The Serious Fraud Office investigation into alleged price fixing on two generic medicines was an issue for the companies involved, said Mr Beighton. "It is difficult to understand some of the issues behind it. Those close to what is going on are a bit bemused."

The NHS could not survive without generic medicines, he said. While there is market protection for branded medicines, the immediate onset of generic competition reduces the drugs bill for that molecule, and provides "headroom" in national healthcare budgets to pay for research into new molecules.

In 2000 generic drugs accounted for 52 per cent of the volume of NHS medicines, but only 22 per cent of the cost. The net ingredient cost of a branded script was £16.06, while that of a generic was £4.18.

And to put things in perspective, Mr Beighton said the increase in the drugs bill as a result of the generic shortages of 1999 was less that the amount the NHS spent on Losec in that year. "Maybe when looking at costs, the Government should not be knocking on our door," he said.

IPMI Conference

LPS – Could it stand for 'last pharmacist standing'?

Pharmacists do not have an exclusive right to run local pharmaceutical services, Dr Darrin Baines, director of medM Ltd, warned delegates at an IPMI conference in Salisbury last weekend.

Dr Baines pointed out that anyone with a legal right to sign a contract – including hospitals, pharmaceutical manufacturers and managed care organisations – could apply to run an LPS pilot.

He painted a picture of "prescription dispensing factories" and American healthcare management organisations operating much of the pharmaceutical service in the UK, and suggested that in 10-15 years many pharmacists would be salaried NHS personnel.

Pharmacists were left with one of two choices, said Dr Baines: concentrate on making a profit through purchasing drugs, or create revenue streams from providing additional services.

In his view, the future of pharmacy lies in diversification and a shift towards thinking of quality in terms of patients' lives rather than just dispensing.

For example, pharmacy services in deprived areas could be run by the public health department of a PCT, with no OTC sales and dispensing limited to certain days.

Dr Baines also warned that if pharmacists refused to take on out-of-hours services, doctors could fill the gap within a couple of years.

Criticising various pharmacy bodies' approach to LPS, Dr Baines said they only appeared to repeat the rules rather than offer strategic advice. "Local pharmaceutical services is the most important thing that has happened to pharmacy since 1948. It is a change in the law – this is serious and it is not going to go away," he said, and stressed that control of entry regulations do not apply to LPS pilots.

Accreditation is likely to play a major part in gaining PCT approval for an LPS scheme.

Miall James said that, as a PCT principal pharmacist, he would want to accredit not just the person carrying out the services, but also the premises and the service provider having applied for the contract.

Superdrug's superintendent pharmacist, Mike Keen, suggested that LPS might get pharmacists the credibility which is not afforded them under the national contract.

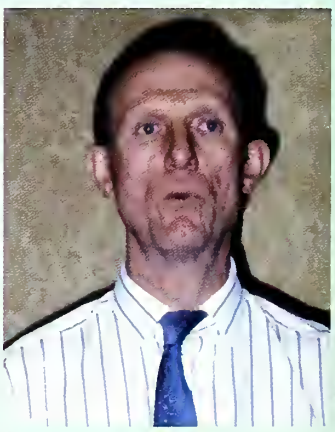
He added that pharmacists had to question whether they had the necessary experience or even wanted the hassle of negotiating these contracts. And he did not rule out the possible introduction of an American-style system of pharmacy-benefit management companies.

Some uncertainty still remains about whether LPS schemes will be allowed to run from the same premises as normal dispensing contracts. Various speakers agreed that, although the Department of Health had ruled out the possibility, it now seemed to take a more flexible view.

Godfrey Horridge, the Pharmaceutical Services Negotiating Committee's finance executive, said the Committee's preferred option would be a new national contract running alongside LPS.

Godfrey Horridge of the PSNC

Dr Darrin Baines, director of medM



Mike Keen of Superdrug

PSNC will propose a new contract with dispensing as the main element but including quality measures, new skill mix and new services. It wants remuneration to be made on an NHS cost of service basis.

Mr Horridge said PSNC was working towards implementation of a new contract in just under a year's time.

Meanwhile, Hemant Patel, LPC secretary (Barking & Havering) and past president of the Royal Pharmaceutical Society, urged the profession to stop concentrating all its efforts on lobbying the DoH.

"Pointing at the DoH has only got a short future – the GP contract was negotiated with the NHS Confederation," he said.

Christina Funnel, from the patient-orientated Health Coalition Initiative, said patients could be powerful allies when considering new services and moves to modernise the profession. "Patients with a chronic condition are often experts in their disease in their own right."

She added: "It is imperative that you stop looking inwards and start working with other healthcare professionals. Patients need you too."

For more information:
www.doh.gov.uk/localpharmaceutilservices

Assessing the risks of extended roles

Pharmacists were urged to consider the legal, commercial and professional risks before embarking on extended services.

Adrian Spooner, a pharmacist and lawyer, said a lot of liability claims arose from people advising on things they were not up to speed on. "When going into new services make sure that you have the knowledge and skills."

He insisted that CPD had to be an integral part of taking on new roles and advised pharmacists to start recording anything they did in order to minimise the professional risk.

Among the commercial risks listed by Mr Spooner were increased competition; the cost of providing the new services (training and a rise in staff wages); and not being assured of remuneration for the service. Furthermore, any element of tendering involved could also seriously affect the business of the person losing the tender.

While a new national contract may be eagerly awaited by pharmacists, Mr Spooner warned: "I cannot see you being able to agree to a new contract without knowing the outcome of the OFT inquiry [into control of entry]."

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CONTRAINDICATIONS: Hypersensitivity to the constituents. Avoid use in pregnancy and lactation. **DRUG INTERACTIONS:** To date there are no known interactions. As with other antihistamines avoid excessive alcohol consumption.
SIDE EFFECTS: Mild and transient drowsiness, headache, dizziness, agitation, dry mouth and gastrointestinal discomfort. Convulsions have very rarely been reported.
PACKAGING/PRICE: Zirtek Allergy: P. Zirtek Allergy Relief: Pack of 7 tablets= £4.45 Retail.
LEGAL CATEGORY: Zirtek Allergy: P. Zirtek Allergy Relief: GSL.
MARKETING AUTHORISATION NUMBER: PL 08972/0032
MARKETED BY: UCB Pharma Limited, Watford, Herts, WD18 0UH.
REFERENCES:
1. IMS Health Midas July 2000 - June 2001.
2. IMS RSA November 2001
FOR FURTHER INFORMATION PLEASE CONTACT: UCB Pharma Limited, UCB House, 3 George Street, Watford, Herts, WD18 0UH. Telephone (01923) 211811. Facsimile (01923) 229002.
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A losing battle?

THE COLLEGE OF PHARMACY PRACTICE

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- To examine possible causes
- To revise basic principles of weight loss
- To understand the classification of obesity
- To appreciate the health risks of obesity

Obesity is on the rise – not just in the Western world but also in many developing countries. Furthermore, the condition seems to be associated with type-2 diabetes and both are escalating at an alarming rate. The future health of generations depends on decisive action taken now to arrest this evolutionary tragedy.

I know I'm fat – but it's in my genes!

Identifying a genetic predisposition to obesity has been welcomed for many reasons, not least for the potential to develop new gene-targeted treatments. Studies have revealed around 250 potential genes for identifying predisposition to obesity.

But the obesity explosion cannot wholly be explained by genetics. Genes may account for metabolic predispositions but environmental factors are more important. It has even been proposed that "selective mating", in which those of a larger body mass index (BMI) procreate with similar people, leading to "clustering" of obesity. There is good evidence showing clustering of obesity in identical twins, regardless of shared or separated environments.

However, these genetic tendencies, although relating one aspect of obesity to another, have not led to the discovery of an obesity gene *per se*. More information is needed before genetic "algorithms" may be tailored, so that individualised dietary intervention can be based on knowledge of differing responses to specific nutrients.

I know I'm fat – but I usually eat anything all day

Almost all studies that follow up weight loss programmes reveal over 90 per cent relapse rates after four to five years, so the question is how those prone to obesity can be converted to a healthy eating plan for life. The answer to obesity is more complex than just eating and running in the short term.

The basal metabolic rate (BMR) is the total baseline energy required to maintain a normal metabolism within all living, respiring body cells. It includes the energy required for digestion and assimilation of nutrients. Additional energy is required for physical activity and exercise. The sum of these is total energy expenditure.

Simply put, when energy intake exceeds expenditure over long periods, an individual becomes obese. The excess calories are laid down as adipose tissue, with significant health risks attached to visceral or abdominal fat.

The tendency to obesity is an evolutionary one. We are designed to "save and store" in times of plenty, for famine, shortage and natural disaster. Nature, it appears, did not expect us to have to cope with an abundance of calories. The real issue is whether regulating calorie intake by dietary measures helps in the long term, and how.

Weight loss is relatively achievable, with or without support. Weight maintenance, on the other hand, requires ongoing

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Cristina Pedrazzini/Science Photo Library

Rear view of the arm and back of a naked obese woman. She is obese as she weighs over 20 per cent more than is desirable for her height, raising the risk of strokes, heart disease and diabetes

◀ Continued from page 19

support, management and motivation. It is the multi-facetted approach of psychology, lifestyle and therapeutics that makes the management of obesity challenging and rewarding at the same time.

I've tried every diet ... but none of them work

The popular media has come up with fads such as cabbage soup diets, eating according to blood groups, separating the intake of different food types and many others. Although extolled by celebrities, there is often no scientific basis for any of these diets. Certainly no randomised controlled trials will have been conducted. Any success is probably down to some form of restricted food intake.

Another problem is that many popular diets are not nutritionally sound and often need to be supplemented by vitamins and minerals.

For successful weight loss, dietary management plays a role but it is not the sole focus of the lifestyle change. Furthermore, the decrease in energy intake needs to be sustained for long periods. Yo-yo dieting, switching from one extreme to another and swapping and changing eating habits is not healthy nor will it be successful.

The result will be a cycle of weight loss, followed by weight gain with alternating periods of soul-destroying restrictions and over-indulgent binge eating.

One thing healthcare professionals agree on is the need for a standard three set meals a day, which will reduce the need for snacks (often energy dense foodstuffs) and prevent impulsive eating habits.

When planning a weight-reducing diet certain principles are worth bearing in mind. The necessary calorie intake can be calculated from an individual's BMR. A deficit of 500–1,000 kcal/day below predicted consumption produces a weight loss of around 0.5–1kg per week. The essential principle is to maintain full nutritional requirements for good health. Common reasons for failure of diets lie in the fact that they are not flexible enough, they do not reflect financial status and personal taste, and they sometimes set unreasonable goals.

Controlling portion size is a reasonable mechanism for reducing calorie intake but bargains such as two for the price of one and "eat-all-you-can" buffets give conflicting messages and encourage increased food intake. Remember – everyone is on a diet. Most people eat a diet they enjoy, an observation that the food industry has exploited *ad infinitum*.

Food contents are often targeted in diets. Fat is the most energy-dense foodstuff, providing more than double the calories per gram when compared with carbohydrates (9kcal/g fat and 4kcal/g carbohydrate). Fat not only provides energy-rich calories, which are likely to be stored, but one can continue eating fatty foods without immediately feeling full. Hunger is satiated more quickly by eating complex carbohydrates. Fat also improves the taste of foods, and studies have revealed that obese people prefer salty, high fat foods. The trend towards low fat foods is reasonable but care must be taken because they do not necessarily contain fewer calories.

Starchy carbohydrates have recently had a bad press. They are perceived by some to be "fattening", probably because they give a feeling of fullness. These foods have low energy density and are inexpensive. The problem is more likely to be the substances with which they are served, such as fat in sauces or butter on bread.

Protein should provide around 15 per cent total energy intake, although most people in the UK eat more than is required.

Fruit and vegetables are vital. Their energy density is low and they are good sources of dietary fibre and micronutrients. Energy-rich foods such as chocolates can still be enjoyed in moderation. Consumption of one chocolate bar does not constitute a relapse! Avoiding excessive dietary restrictions will avoid excessive cravings.

Most seriously, restricting water intake is never a strategy for weight loss. Both diuretics and laxatives have been abused with this in mind.

Very low calorie diets (VLCD) and commercial meal replacement products provide under 600kcals per day. The Committee on Medical Aspects of Food Policy (COMA) guidance in 1989 contra-indicated these products in pregnancy, breast-feeding, children and the elderly. The USA and EU differ notably in their approach to meal replacement regulation. The EU has far more stringent manufacturing regulations than the USA and, whereas controlled advertising claims are allowed there, they are not in the EU.

However, these diets appear to result in successful weight loss. Concern about their use centres on dramatic reductions in weight

Continued on page 22 ▶

Table 1: Classification of obesity by BMI and waist circumference

		Disease risk relative to normal weight and waist circumference	
	BMI (kg/m2)	Men < 102cm Women < 88cm	Men > 102cm Women > 88cm
Underweight	< 18.5	-	-
Normal weight	18.5 – 24.9	-	-
Overweight	25.0 – 29.9	Increased	High
Obesity I	30.0 – 34.9	High	Very high
Obesity II	35.0 – 39.9	Very high	Very high
Obesity III	> 40.0	Extremely high	Extremely high

National Institute of Health, October 2000

References:

1. Friedrich HC, et al. Efficacy of Mycospor Cream in the treatment of mycoses of the foot. *Z Allg Med* 1992; 68: 325–329.

2. Lücker PW, et al. Retention Time and Concentration in Human Skin of Bifonazole and Clotrimazole. *Dermatologica* 1984; 169(1): 51–55.

Canesten CAN

- Bifonazole is the new active ingredient from Canesten, offering the first water-resistant treatment for AF [1]

Canesten® AF
ONCE DAILY
BIFONAZOLE CREAM
FOR ATHLETE'S FOOT
NEW

- Bifonazole penetrates the skin [1] giving 24-hour,[2] broad-spectrum activity, and providing effective treatment for the whole foot [1]

The only water-resistant, ONCE DAILY azole for athlete's foot

Table 2: Health benefits accrued from 10 per cent body weight loss

(10kg loss from a patient weighing 100kg)

Mortality	20–25% fall in total mortality
	30–40% fall in diabetes related deaths
	40–50% fall in obesity related Ca deaths
Blood pressure	10mmHg reduction in systolic and diastolic
Diabetes	Reduce risk of diabetes by over 50%
	Reduction fasting blood glucose = 30–50%
	Fall HbA1c of 15%
Lipids	10% drop total cholesterol
	15% drop in LDL
	30% drop in TG
	8% increase in HDL

Clinical Management of Overweight & Obese Patients, produced by the Royal College of Physicans, December 1998, table adapted from Jung (Obesity as a Disease. Br Med Bull 1997; 53: 307–21)

◀ Continued from page 20

and in the BMR. Lean muscle mass may also be lost, particularly if the individual is not obese. There is more support for the replacement of one meal daily with a VLCD drink. These are often more nutritionally complete than the patients' usual diet.

I know I am fat – but it must be my brain telling me to eat

Central nervous regulation of energy balance occurs in the hypothalamus. Peripheral responses from the stomach, liver and adipose tissue generate both short term (after a meal) and long term (total body stores) signals, which then determine future food intake and, to some extent, energy expenditure. Thermogenesis, the process of heat production by adipose tissue via sympathetic stimulation, also falls under the remit of the hypothalamus.

Over 40 neurotransmitters have been identified that control both calorie expenditure and intake. Patients suffering from hypothalamic tumours or who have undergone surgery for craniopharyngiomas show increased appetite resulting in weight gain.

In addition, two melanocyte stimulating hormones (alpha and beta) act on melanocortin 4 receptors to reduce food intake.

On its discovery, leptin was hailed as the key to success in obesity management. Leptin is an adipocyte derived hormone, of which the target organ is, again, the hypothalamus.

As leptin levels rise, those of neuropeptide Y (an appetite stimulating neurotransmitter) fall. In mice, leptin deficiency leads to increased calorie intake and reduced energy expenditure, resulting in severe obesity.

Though rare in humans, leptin deficiency results in severe, early onset morbid obesity. But, while leptin is lacking in genetic obesity, there are high levels in "common" obesity and trials of recombinant leptin have produced disappointing results.

Resistin, another hormone linked to obesity, is currently undergoing evaluation and preliminary data holds significant promise in unlocking secrets within this Pandora's box.

So what if I'm fat? I'm happy with my body and I feel great

Obesity has far-reaching implications on health *(see Table 1)*. Even just being overweight (BMI 25–30kg/m^2) increases health risks, the main cause of increased mortality being cardiovascular disease. The risk of coronary heart disease and hypertension is increased two to three times if the BMI is over 26, and more when the BMI is over 30. The lowest mortality occurs with a BMI between 19–24.

The closest relationship between obesity and any disease is propensity to type-2 diabetes. Where a family history is present this is almost predictive. Fat distribution around the abdomen is the main risk, rather than obesity *per se*. Adipose tissue in the abdominal cavity has high lipolytic rates, releasing free fatty acids that drain directly into the liver via the portal circulation.

Flooding the liver in this manner has a direct negative impact on hepatic glucose homeostasis; insulin mediated inhibition of glycogenolysis is reduced and peripheral muscle uptake of glucose is impaired. Insulin resistance develops and impaired glucose tolerance results in hyperinsulinaemia and profound dyslipidaemias.

Raised plasma triglycerides (through impaired clearance), reduced high density lipoprotein (HDL) -cholesterol and high levels of low density lipoprotein (LDL)-cholesterol generate the small, atherogenic LDL-particles that contribute directly to coronary risk. Readily oxidised and taken up into the vascular endothelium, macrophages and monocytes mop up oxidised-LDL, driving inflammatory atherosclerotic processes and resulting in the development of arterial disease.

Cardiovascular risk in obesity is further enhanced by demands made on the left ventricle for increased output to meet requirements of extra body mass, which can eventually progress to left ventricular hypertrophy (LVH).

Respiratory disorders, particularly obstructive sleep apnoea syndrome, are well documented in obesity. Excess fat deposited in the neck, chest wall and abdomen has adverse effects on lung function. Apnoeic episodes can lead to pulmonary hypertension, myocardial stress, excessive daytime drowsiness and altered tissue oxygenation during the night.

The World Health Organisation (WHO) says that, after smoking, obesity is the next most preventable cause of cancer. Colon, gallbladder and endometrial cancers have all been linked to obesity. Further evidence links obesity to infertility and polycystic ovarian disease.

Actionplan

Obesity Part 1

1. Obtain a table showing height/weight/body mass index relationship. Keep this handy when discussing weight problems with clients. What is the ideal BMI? Does it vary with age, sex or race?
2. Using this index, try to find out how many of your patients/clients are obese. This will require estimates of their weight and height. Record your assessment in your practice workbook, relating it to age, sex and perhaps ethnic group. Can you draw any conclusions?
3. The article states that relapse to obesity occurs in 90 per cent of cases, four to five years after a weight loss programme. Is this a fair test of the failure of such programmes? Discuss this with colleagues.
4. What is the difference between satiety and hunger? How important is each of these in controlling weight?
5. Do you know any patients who have type- 2 diabetes and are obese? When diagnosed and treated did their weight reduce?

Distance learning for pharmacists

Pharmacists using **Pharmacy Update** for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C&D's readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the June 1 issue, which will cover this week's CPP-accredited modules, together with those in the May 11 and May 25 issues.

These will cover:

● **Obesity Part 1 (1234)** ● **Obesity Part 2 (1235)** ● **MI (1236).**

A telephone marking service offers independent verification of results – details on the monthly MCQ papers. People wanting to register for Pharmacy Update can contact Mary Prebble on 01732 377269.

Revealing confidence in psoriasis

is® Ointment Prescribing Information

sentation: 3 micrograms/g calcitriol ointment. **Indications:** Mild to moderately severe plaque psoriasis *oriasis vulgaris).* **Dosage and Administration:** Adults Only - Apply twice daily (morning & evening) before ing and after washing. There is limited clinical experience available for this dosage regimen of more than eeks. **Contra-indications:** Patients with kidney/liver dysfunction, hypercalcaemia, abnormal calcium abolism, on systemic treatment of calcium homeostasis, or sensitivity to any ingredients. **Precautions Warnings:** Not to be applied to the face. Not recommended for use on more than 35% body surface , maximum use 30g per day. Do not cover with occlusive dressing or use substances which stimulate orption. Reduce or discontinue use if sensitivity or severe irritation occurs. **Side Effects:** Skin irritation dening or itching). **Interactions:** Use with caution in patients receiving medications known to increase m calcium levels, calcium supplements or high doses of vitamin D. Concomitant use of peeling agents, ngents or irritant products may increase irritant effects. **Pregnancy and Lactation:** Not recommended ng pregnancy or lactation unless considered essential by the physician. **PL Number:** PL 10590/0047. **kage Quantities and Basic NHS Cost.** Tubes of 100g (£24.00) or 30g (£7.20). **Legal Category:** POM. **prescribing information is available from the marketing norisation holder:** Galderma (UK) Limited, Galderma House, Church e, Kings Langley, Herts. WD4 8JP, UK. Tel: +44 (0)1923 291033, Fax: (0)1923 291060. **Date of preparation:** March 2002.

GALDERMA DEDICATED TO DERMATOLOGY

SILK/09/0402

Silkis®

calcitriol 3 micrograms/g

New confidence in psoriasis

Frequently administered interferon better for MS

High dose interferon beta-1b administered on alternate days is a more effective treatment for relapsing-remitting multiple sclerosis than interferon beta-1a given once a week.

The Independent Comparison of Interferon (INCOMIN) study, published in *The Lancet*, was designed to compare the clinical and magnetic resonance imaging benefits of the different treatment regimes.

In the two-year prospective, multi-centred, randomised study, 188 patients received alternate-day interferon beta-1b 250 micrograms or once-weekly interferon beta-1a 30 micrograms.

After two years, 51 per cent of patients in the interferon beta-1b group had not relapsed compared with 36 per cent in the beta-1a group. The differences between the two treatments increased during the second year. Interferon beta-1b also had a significant benefit for most of the secondary outcome measures, including delay of confirmed disease progression.

However, the authors say that further studies are required to compare the two treatments when both are given frequently to "address any outstanding questions with respect to the relative efficacy and tolerability of the two drugs".

Lancet, 2002;359: 1453-1460

For more information:
www.thelancet.com

Thalidomide again in UK?

Thalidomide may be available in European countries, including the UK, following the European Agency for the Evaluation of Medicinal Product's acceptance o a marketing authorisation.

The Celgene Corporation has applied to the EMEA to market Thalomid as a treatment for refractory multiple myeloma and erythema nodosum leprosum, an inflammatory condition of leprosy

Thalomid received clearance from the US Food & Drug Administration in July 1998. To minimise the risk of errors in prescribing or dispensing, only doctors and pharmacists registere with a safety distribution program may supply the drug.

Avoid aspirin for teenagers

Aspirin should be avoided in children aged 15 years or under if feverish, following latest advice from the Committee on Safety of Medicines.

Since 1986 the British Paediatric Surveillance Unit has reported 10 cases of Reye's syndrome in children over 12, says the latest issue of *Current Problems in Pharmacovigilance*. Health professionals, including pharmacists, are reminded that all cases of Reye's syndrome should be reported through the yellow card system.

Advice on aspirin use for children under 12 remains unchanged.

The new *BNF*, number 43, includes this advice on aspirin as well as updated sections on vaccines, myasthenia gravis, anthrax and multiple sclerosis

For more information:
www.mca.gov.uk

Breath test as effective as endoscopy

A breath test for *Helicobacter pylo* has been shown to be as safe and effective as endoscopy in detectin peptic ulcer disease, according to study in the *BMJ*.

The non-invasive breath test f *H. pylori* should be the preferred mode of investigation as it is less uncomfortable and distressing fo the patient, say the authors.

In a randomised, controlled tr of 586 patients under 55 referre for investigation of dyspepsia, 2 received endoscopy and a C-ure breath test, and 294 had the brea test alone. Patients were followe up at 12 months and the mean change in the Glasgow dyspepsi severity score was similar in bot groups.

Despite concerns that a breat test may not detect malignancy, patients over 55 or with sinister symptoms were excluded from trial. Previous studies have sho that malignancy in the investiga group is extremely rare.

More than one per cent of th UK population undergoes gastroscopy each year, despite l of evidence to support the use endoscopy in the management dyspepsia.

The authors suggest the non invasive breath test is not only convenient but substantially cheaper than endoscopy.

BMJ 2002, 324: 999-1001

For more information:
www.bmj.com

Action plans help asthmatics

Asthmatic patients who receive an action plan from their GP to help manage their asthma view them positively, according to a study in the *BMJ*.

In the qualitative study, 62 patients who presented to an emergency department with an asthma attack over a two-month period were assessed for their use of action plans.

Just under half (29) of the patients had been given action plans by their doctors but most of them re-interpreted the plan from the perspective of their own experience. Thirty-three patients did not have an action plan, most commonly because they had not been given one by their doctor. However, some had devised their own "plan of action" and many were medically credible.

The authors conclude that to help implement a prescribed action plan doctors must acknowledge, and include, the patient's personal experience.

Action plans are one of the recommendations for optimum care devised by the Global Initiative in Asthma. Written plans have been shown to improve asthma outcomes and be a major protective factor against death from the disease.

BMJ, 2002; 324: 1003-1005

Allen & Hanburys has developed a website to assist healthcare professionals involved in managing asthma in primary and secondary care. The site includes links to news on asthma, patient fact sheets, recommended guidelines, self-assessment questionnaires and links to related websites. *www.seretide.co.uk*

For more information:
www.bmj.com

Frontshop

Alcon's Alomide is one in the eye for allergies

Alcon Laboratories is introducing its OTC Alomide Allergy Eye Drops into pharmacies nationwide. The allergy eye solution, which recently switched from POM to P status, was launched in Boots last year.

Containing 0.1 per cent lodoxamide, the product inhibits histamine release, helping to block the allergic reaction.

Designed to provide relief from red, itchy hay fever eyes, the drops are formulated to treat non-infectious, allergic conjunctivitis such as seasonal allergic conjunctivitis.

The product is suitable for adults and children over four years old. Soft contact lenses should not be worn while using the product.

The launch will be supported by an £80,000 promotional campaign. Point of sale material includes shelf wobbler, dummy packs and window posters.

A special offer of 10 for the price of six is available for pharmacies.

Price: £4.09

Pack size: 5ml
Pip code: 285-9668
Alcon Laboratories (UK) Ltd
Tel: 01442 341234.

Paramol is easier to swallow

SSL International is relaunching Paramol in a smooth-coated, caplet-shaped tablet.

Containing paracetamol and dihydrocodeine tartrate, the caplets are designed to meet consumer demands for an easier to swallow tablet.

The tablets are available in packs of 12, 24 and 32.

The relaunch will be supported by point of sale material.

Price: £2.59 for 12, £4.39 for 24, £4.99 for 32

SSL International plc
Tel: 0161 654 3000.

Folic Plus is in the pink

Peter Black Healthcare is relaunching Folic Plus with a bright new look.

The folic acid supplement, which is part of the Calcia range, has been repackaged in eye-catching cerise pink packs featuring a mother with infant visual.

The pack also highlights a consumer helpline.

In addition to folic acid, the product provides 100 per cent RDA of calcium and vitamin D.

The relaunch will be supported by a summer advertising campaign in pregnancy and parenting magazines.

In-store point of sale material includes a new consumer leaflet for women trying to conceive or who are already pregnant.

The leaflet gives tips on the healthy development of the unborn child and background on folic acid and other key nutrients.

Price: £3.39

Pack size: 90 tablets
Pip code: 086-0437
Peter Black Healthcare Ltd
Tel: 01283 228373.

Eucerin targets new customers

Beiersdorf is introducing a new look for the Eucerin dry skin range to help pharmacists attract new customers.

Eye-catching packs feature benefit-oriented product names to help customers select the right product for their needs.

The brand name and colours remain the same so the product is still easily recognisable to existing customers.

The relaunch will be supported by a £350,000 press advertising campaign, starting in September, and new point of sale material.

The Eucerin website has recently been relaunched. Targeting both consumers and medical professionals, the site provides information on eczema and dry skin conditions.

For more information:

Beiersdorf UK Ltd
Tel: 0121 329 8800
www.eucerin.co.uk

Scriptlines

Leo launches Dovobet

Leo Pharmaceuticals has this week launched Dovobet ointment for the treatment of stable plaque psoriasis.

Each gram of ointment contains calcipotriol 50mcg and betamethasone dipropionate 0.5mg. It should be applied to the affected area twice daily for no more than four weeks, in patients aged 18 years and over.

Treatment of more than 30 per cent of the body surface area should be avoided. The maximum daily dose should not exceed 15g and the maximum weekly dose should not exceed 100g.

Common undesirable effects include pruritus, rash and folliculitis. Once opened the product has a shelf life of three months.

For more information:

Price: £55
Pack size: 120g
Pip code: 286-4015
Leo Pharmaceuticals
Tel: 01844 347333.

New malaria treatment

Novartis has launched a treatment for acute uncomplicated *plasmodium falciparum* malaria.

Riamet (artemether 20mg and lumefantrine 120mg) is indicated in adults and children aged 12 years and over and who weigh 35kg and over.

The Prescription Only Medicine is administered as six doses of four tablets over 60 hours. The first dose should be followed by five further four-tablet doses at eight, 24, 36, 48 and 60 hours.

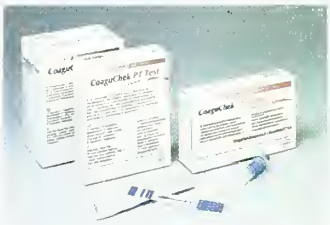
Adverse effects include headache, dizziness, sleep disorder, abdominal pain, diarrhoea, rash and cough.

For more information:

Price: £22.50
Pack size: 24 tablets
Pip code: 282-6865
Novartis Pharmaceuticals
Tel: 01276 692255.

Scriptlines

INR test strips on FP10



Test strips for anticoagulation monitoring by patients are available on prescription from May 1.

A finger prick of blood is placed on a CoaguChek S test strip, which is then placed in the CoaguChek S photometer. The patient's prothrombin time and INR status is displayed in one minute.

The test strips are available from wholesalers but the photometer has to be purchased from Roche at £399 plus VAT.

For more information:

Price: £30 12s, £117.30 48s
Pack size: 12s and 48s
Pip code: 287-5559 12s, 287-5607 48s
Roche Diagnostics
Tel: 01273 480444.

Silkis for psoriasis

Galderma has launched Silkis (calcitriol 3mcg per gram) ointment for the treatment of mild to moderately severe plaque psoriasis.

The Prescription Only Medicine inhibits the proliferation and stimulates differentiation of keratinocytes. It also inhibits proliferation of T-cells and normalises the production of various inflammatory factors.

Silkis should be applied to the affected area twice daily. No more than 35 per cent of the body surface (roughly one arm and one leg) should be exposed to daily treatment. The ointment should not be used on the face because of an increased risk of irritation. Excessive use can lead to systemic side effects such as an increase in urine and serum calcium levels.

Local side effects include skin irritation (reddening and itching).

For more information:

Price: £7.20 (30g), £24 (100g)
Pack size: 30g, 100g
Pip code: 287-0194 (30g), 287-0202 (100g)
Galderma UK Ltd
Tel: 01923 291033.

Frontshop

Vichy launches suncare centres for pharmacies

Vichy is offering independent pharmacies the chance to host a safe sun initiative for the first time this summer. Special events can be run for any two weeks in June, July and August.

The company has developed its Sun Protection Centres in conjunction with the Cancer Research Beachwatch Campaign and the British Skin Foundation. Over the past two summers, events have taken place in public areas and branches of Boots.

A special kit (free to Vichy stockists) is available to provide everything necessary to run a Sun Protection Centre in store.

The kit contains diagnostic tools to assist in advising customers on the right level of protection for them. Tools include a melanometer – a lightweight electronic device to measure the level of melanin in the skin and determine the optimum SPF for each consumer. The kit also has selling tips, equipment, samples and show material.

Vichy is running a competition offering the chance to win an advertisement for your pharmacy in your local newspaper, and a selection of summer essentials and vouchers worth £250.

For more information:

Cosmetique Active (UK) Ltd
Tel: 020 8762 4177.

Swiss beauty line for UK

Best known for its nailcare products, the Swiss company Mavala is introducing a facial skincare and make-up line into the UK.

The Mavalia range features five skincare products: Comfort Cleansing Milk, Smooth Toning Lotion, Specific Toning Lotion, Multivitamin Cream and Hydro-Active Night Cream. They all contain mallow – a plant extract from the Alps with smoothing and astringent properties. A travel pack of the products is also available.

The range also includes six facial make-up products: Tinted Cream, Blush, Wet & Dry Powder, Loose Powder, Pressed Powder and Fluid Foundation. An elegant tester display unit and colour chart is available.

Mavalia was launched in Harrods last month and is now available to pharmacies.

Price: Skincare products range from £9.50 to £29.50

Mavala (UK) Ltd
Tel: 01732 459412.

Eye opener from Nivea

Beiersdorf is launching an anti-shadow eye cream into the Nivea Visage range.

Nivea Visage Anti-Shadow Eye Creme is a light cream containing cucumber extract, ginseng and light reflecting pigments to help diminish under-eye shadows and reduce puffiness.

The manufacturer claims the cream will significantly reduce puffiness and dark circles within four to eight weeks.

The product includes mineral UVA and UVB filters and vitamin E to help prevent light-induced premature skin ageing.

The formulation is free from fragrance, colourants, chemical light filters and alcohol.

Price: £7.99

Pack size: 15ml
Pip code: 286-6440
Beiersdorf UK Ltd
Tel: 0121 329 8800.

Strength without the sting

New from Almay is a range of hypo-allergenic deodorants for sensitive skin.

Almay Anti-Perspirant Deodorants are formulated to offer long-lasting protection from odour and wetness without any irritation or discomfort, even after shaving.

The deodorants come in four formats – roll-on, solid, aerosol and cream. All the products are formulated without fragrance, colour or oil.

The white and pink packaging has a stylish, feminine look.

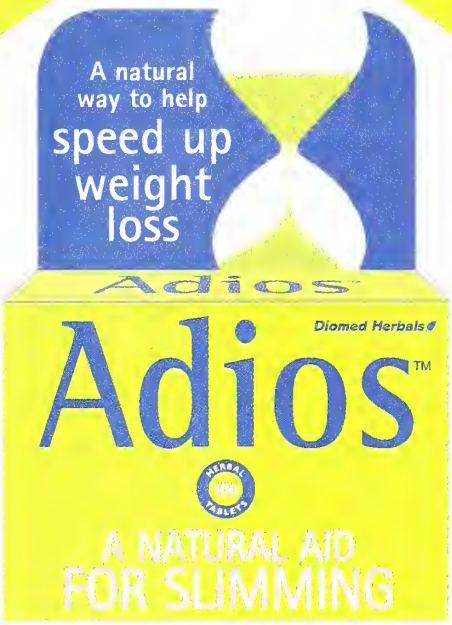
Also from Almay is its new Skin-Smoothing Foundation with Kinetin, a hypo-allergenic foundation. Kinetin is found in green, leafy plants. The cream ge product (£9.99) also includes the Almay Botanical Line Smoothing Complex comprising gingko bilob green tea, ginseng and grape see extract. It is formulated to offer anti-ageing benefits and make-u in one product. Shades are Buff, Naked, Sand and Honey.

Price: Roll-on £1.69, Solid £2.59, Aerosol £2.19, Cream £2.59

Revlon International Corporation
Tel: 020 7284 8700.

NATIONAL ADVERTISING CAMPAIGN

MAKE THEIR WEIGHT LOSS YOUR GAIN



fucus, boldo, butternut and dandelion root

Adios herbal tablets contain natural ingredients which act on the body's metabolism, to help speed up weight loss.

ADIOS Trademark and Product Licence held by Diomed Herbals, Hitchin, Herts, SG4 7QR, UK. Distributed by DDD Ltd, 94 Rickmansworth Road, Watford, Herts, WD18 7JJ, UK. **Directions:** Adults and elderly: Take one tablet three or four times a day at mealtimes, as part of a calorie controlled diet. **Indications:** A herbal remedy traditionally used as an aid to slimming. **Contra-indications:** Not to be taken by children under 16 years. Not to be used if allergic to any of the ingredients. Not to be used during pregnancy or lactation. Do not store above 25°C. **Legal Category:** GSL **Packs:** Adios (PL 17418/0005) - 100 tablets, RSP £9.95 (£8.47 exc. VAT).

Frontshop

Palmer's Shea Butter Formula goes nationwide

Following a trial in pharmacies last year, Palmer's Shea Butter Formula skincare range is being launched nationwide this month.

The products are formulated with pure, natural shea butter which is known for its moisturising abilities.

The range will initially comprise two products: Shea Butter Formula Lotion with Vitamin E – a light body moisturiser that is quickly absorbed; and Shea Butter Formula Original Jar – an intensive moisturiser to soften and rehydrate dry skin.

Both products have a fresh, tropical fragrance.

The launch will be supported by an advertising campaign in women's magazines from June until the end of the year.

Price: £4.25

Pack size: Cream 100g, Lotion 250ml
Pip code: Cream 284-2318, Lotion 284 2300
E T Browne (UK) Ltd
Tel: 020 8554 7000.

Jungle Formula wipes up family sales

Chefaro has introduced wipes into the Jungle Formula insect repellent range.

Packed in individual sachets to prevent them drying out, the wipes give up to eight hours protection and can be used on children from three years old.

The Family Lotion in Jungle Formula's Standard range has been reformulated to make it suitable for children from the age of six months and people with sensitive skin.

The lotion now includes almond oil and aloe vera while the active ingredient, IR3535, is unchanged.

Price: Wipes £4.49 (15 sachets; Lotion (175ml) £6.99

Pip code: Wipes 282-6337; Lotion 259-2228
Chefaro Proprietaries Ltd
Tel: 01480 421800.

Inbrief

Sahara suncare

Pharmadass has introduced the Sahara suncare range. It comprises six sun protection lotions – SPF 25 for kids, SPF 25 for adults, SPF 20, SPF 15, SPF 10 and SPF 8 plus an after sun moisturising lotion. Prices range from £3.99 to £5.99.

For more information:
Pharmadass Ltd
Tel: 020 8426 3400.

Octovite update

After six months of being out of stock, Octovite tablets are available again through wholesalers or direct from Intrapharm Pharmaceuticals.

For more information:
Intrapharm Laboratories Ltd
Tel: 01622 749222.

Spikes are us

Wella has agreed a sponsorship deal for its Shockwaves brand with Pop Idol finalist Gareth Gates. The company is confident the endorsement will increase sales as teenagers mimic Gareth's trademark "spikes". The singer will endorse the full range across the campaign until December.

For more information:
Wella Great Britain
Tel: 01256 320202.

Scriptlines

Xalatan first line treatment

Xalatan (latanoprost 50mcg) eye drop solution has been approved as first-line treatment to reduce elevated intraocular pressure in patients with open-angle glaucoma or ocular hypertension.

For more information:
Pharmacia
Tel: 01908 661101.

Amaryl and metformin

Aventis Pharma has updated the Summary of Product Characteristics for Amaryl (glimepiride) tablets which can now be used with metformin in patients not adequately controlled with the metformin maximum daily dose. While maintaining the metformin dose, glimepiride therapy is titrated up to the required dosage.

For more information:
Aventis Pharma
Tel: 01732 584000.

New standard for organic beauty/health products

A wide range of organic health and beauty products will carry the Soil Association label under new standards established by the organisation on May 1.

The Soil Association symbol will assure consumers that products have been independently audited for organic authenticity.

Under the standards, products containing at least 95 per cent organic ingredients can be labelled organic. Products with no less than 70 per cent organic ingredients may be labelled "made with xx per cent organic ingredients".

Prohibited ingredients and processes include hydrogenated fat, ingredients of petro-chemical origin, lauryl sulphate and sodium laureth sulphate.

For more information:
The Soil Association
Tel: 0117 914 2444.

TV next week

Anadin: All areas
Benadryl Allergy Relief: B, G, Y, A, HTV, W, M, LWT, TT
Bodyform Micro: All areas
Calpol Fast Melts: All areas except U
Eumovate: All areas except U, CTV
Feminax: GTV, B, G, Y, C4, C5
Imodium: All areas
Lucozade Sport: All areas except U, CTV
Macleans Whitening: All areas except U, CTV
Movelat Relief: C5
Oxy: Sat
Panadol: All areas except U, CTV
Poligrip: All areas except U, CTV
Ribena: All areas except U, CTV
Wella Vivality: All areas except GTV, B,Y, A, CTV, TT
PharmaSite for next week: Piriton – Window, **Beconase** – In-stor
Canesten Once – Dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, C5-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Ultima

Hold-ups

...elping to prevent Deep Vein Thrombosis (DVT), Varicose Veins and tired, aching legs

More people than you might think are at risk from developing a DVT. For example those whose occupation involves long periods standing or sitting; people travelling on long-haul flights[1]; and pregnant women (around 1 in 1000 pregnant women and 2 in 1000 women post-natally will suffer a DVT[2]; and 15%-20% will develop varicose veins[3]).
That's why Scholl, the leading name in compression hosiery, has developed NEW Scholl Ultima Hold-ups.

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- Can help prevent the development of DVT and varicose veins
- Recommended for long haul fliers at risk from developing DVT[1]
- Class I compression is recommended by the Department of Health for the prevention of varicose veins during pregnancy[4]

... and for you

- All expectant mothers are entitled to free compression hosiery on prescription throughout the term of their pregnancy and for up to 12 months after giving birth
- Scholl Ultima Hold-ups can be dispensed against generic Class I thigh length prescriptions
- POR 40%
- A comprehensive set of point of sale materials

For more information, call **01565 625174** or return the coupon to: Ultima Hold-ups, SSL International, FREEPOST OL321, Tubiton House, Oldham OL1 3BR.

I would like further information about Scholl Ultima Hold-ups and how they can help prevent DVT and a set of point of sale materials.

Name

Practice Address

Postcode Tel No

References
1. The predisposing factors to DVT as identified by the House of Lords Select Committee on Science and Technology, 5th Report on Air Travel and Health 2001.
2. Letsky EA. Thromboembolism during pregnancy. In: Coagulation problems in pregnancy. Current reviews in obstetrics and gynaecology. London: Churchill Livingstone, 1985 . 29-61
3. Nabatoff RA (1960) Varicose veins in pregnancy. *Jnl Am Med Assoc.* 174. 1712-16.
4. The Drug Tariff, March 2002.

C+D2

SSL International

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Scholl THE LEADING NAME IN COMPRESSION HOSIERY

We asked candidates this year to state whether they agreed or disagreed with 12 statements relating to current issues being discussed within the profession. Candidates were then given the opportunity to expand their views on up to three themes identified in the questions. Here are their responses.

In my

	G Alexander Community	R Carrington Community	Dr S Chaudary Academia	Dr S Cockbill Academia	R Darracott Community
1 Should the RPSGB be the registering body for pharmacy technicians?	No	Yes	Yes*	Yes	Yes
2 Should the RPSGB continue to represent all pharmacists as well as regulating them?	No*	Yes	Yes	Yes*	Yes*
3 Will the pharmacist ever be able to supervise a pharmacy without being on the premises?	No*	No*	Yes*	Yes	Yes
4 Should all RPSGB Council members be in the first wave of the CPD programme?	Yes	Yes	Yes	Yes	No
5 Should detailed Society and Council expenses be available for inspection by the membership?	Yes	Yes	Yes	Yes	Yes*
6 Is Council exercising its right to hear matters in closed session appropriately?	?	No	Yes	No	No
7 Does the Society represent employee pharmacists appropriately?	No	Yes*	No	No	Yes
8 Should the Society relocate from its Lambeth headquarters?	No	No	No	No	No
9 Is the sharing of responsibilities and workload between Council members and directors appropriate?	No	No	Yes	No*	No
10 Should the President be elected directly by the membership?	No	No	No*	No	No
11 Are you satisfied that the extra revenue raised frrom the retention fee will be spent as indicated?	No	Yes	No	Yes	No
12 Does the BPC have a future as an event for community pharmacists?	Yes	Yes*	Yes	Yes	Yes

Gerald Alexander
Community Pharmacy

3 Supervision is all about patient safety. Our principal role is to ensure patients take medicines appropriately. In exercising supervision we must demonstrate we add value to patient care. It is difficult to see how this can be done where a pharmacist is not on the premises! Pharmacies operating without a pharmacist would weaken the strength of access to a pharmacist whenever the pharmacy is open. The best arrangement has to be where there is direct pharmacist involvement in patient care, whether through clinical assessment of a prescription, or through provision of advice associated with the supply of medicines. If community pharmacies can be run without pharmacists, what do we need pharmacists for?

2 The Society does a good job in executing its regulatory role – but I believe it has not played a significant and credible part in representing the membership. If a conflict of interest is perceived, it is loath to speak up against "the public interest" – even where membership interests could be represented.

We need to debate this for the sake of our profession's future. Difficult decisions and choices will have to be made – and sooner rather than later. Otherwise, the Government will do it for us!

Roy Carrington
Community Pharmacy

3 I firmly believe there must be a pharmacist present on the premises in order to supervise the pharmacy and its activities. I do not believe pharmacists need to check every prescription at the time of dispensing. But qualified dispensing technicians should be able to carry out dispensing functions in accordance with agreed standard operating procedures, without the pharmacist's direct involvement. Pharmacists must, however, remain available on the premises for referral, for immediate access, and to accept responsibility for all actions undertaken within the pharmacy.

7 While I have answered "yes", this does not mean I believe the Society necessarily represents all pharmacists as well as it could, including employee pharmacists. The Code of Ethics, in particular, indicates the importance the Society places on employee pharmacists' responsibilities and rights as to how they practice. Equally, it acts as a protection for employee pharmacists who may be asked to perform duties or engage in activities that they would not wish to do.

12 BPC ought to be a keynote event in the pharmacists' annual calendar. The challenge for the new Council is to ensure that the Conference agenda engages the interest of community pharmacists, and delive outcomes meaningful to their daily practice.

Dr Shaqil Chaudary
Academia

1 If we are to take on greater roles within healthcare, we must delegate duties to other members of the pharmacy team, ie the technicians. As a mechanism of quality assurance, registration of pharmacy technicians can only be a good thing. In my opinion the most obvious organisation to be involved in this process is the RPSGB.

3 The laws on supervision relating to sales/dispensing of pharmacy medicines were put forward to ensure accountability and maintain high standards. Note that it is the person being supervised, not the transaction so in legal terms it would be possible. The Society's traditional interpretation requires having a pharmacist physically present in the professional area. There are arguments as to whether the Society's current interpretation is beneficial or a hindrance. Provided relevant protocols were in place, I believe a change in the current interpretation of the supervision rules need to be actioned.

10 The Council is elected directly b members. But, in terms of a president, the Council members, through regular contact, are likely t understand his/her views and thought processes.

In this light, I feel Council members are more likely to make a more informed choice on the suitability of a candidate for president.

opinion...

Candidates for this year's election to the Royal Pharmaceutical Society's Council give their views

W Dawson stry	D Emson Community	R Gartside Community	C Glover Health	Dr G Hawksworth Community	P Hoare Community	C Jackson Policy	H Patel Community	P Schofield Community	A Soni Community	P Walton Community
s*	Yes	Yes*	Yes	Yes	Yes	Yes*	No	No	No*	Yes
s*	Yes*	Yes*	Yes	Yes	Yes	Yes	Yes	Yes*	No	Yes
s	No*	Yes*	No*	Yes*	(Yes)	Yes	No	Possibly	No	No
s	Yes	Yes	Yes*	No*	Yes*	No*	Yes	Yes	Yes	Yes
s	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
	No*	-	Yes	No	No	-	No	No*	No*	No
	No	No	No*	Yes	No	No	No	No*	No	No
	No	No	No	No	No*	No	No		No	No
	Yes	-	Yes	Yes	No	No	No	No	No	Yes
	No	No	No	No	Yes *	No	Yes	Yes	No	No
s*	Yes	Yes	Yes	Yes	Yes	No*	Yes	No	No	?
s	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes*	Yes

* = questions referred to in expanded answers

Dr Sarah Cockbill
Academia

2 An unequivocal yes. Pharmacy is a small and fragmented profession. It is essential to have a body such as the RPSGB to overarch the diverse interest groups and give a credible, representative viewpoint to government and other professions. There is unease among pharmacists about the precise way CPD will be implemented by the RPSGB. It follows that those making the decisions should take the lead and illustrate to the membership what will be acceptable and demonstrate how any penalties prescribed for non-compliance will be undertaken.

9 Laudable recommendations for professional development derived from the PIANA exercise also resulted in the establishment of the working party which focused on the role of Council and its Committees. Implementation of its recommendations has fundamentally disestablished Council and changed its mechanism for dealing with its business. Changes in staff working, implemented concurrently, have led to the appointment of non-pharmacists as Society directors so it has almost become a disadvantage to be a pharmacist employed by one's professional body. It is essential that this trend be reversed to enable the Society to again be of real value to its membership.

Rob Darracott
Community Pharmacy

1 Given a "yes/no" choice I say "yes", although this is a complex issue. There are advantages to the Society in pharmacy support staff being registered, but this begs some questions. We need to see a definition of "pharmacy technician". We need to consider how the qualification for registration relates to existing qualifications. We need to decide – and those working now will need to know – whether registration is "nice to have" or "must have", and by when. That's before we consider whether the Society will simply hold a register, or do rather more.

3 Ignoring the semantic argument about whether you can answer "no" to a question including the word "ever", my work brings me into regular contact with pharmacists in The Netherlands who remain responsible for a pharmacy in their absence from the premises. As professionals we ought to be confident enough to re-interpret "supervision", "responsibility" and "accountability" in line with changes in technology, practice and public, political and professional perception.

5 That this question needs to be asked at all, particularly in relation to the Council, says we have a problem. The spectacular increase in this year's fee demands a considerably improved level of transparency.

Prof William Dawson
Industry

2 The RPSGB must continue to both represent and regulate pharmacists. While I am totally in support of the regulatory function being conducted by a body with a strong lay presence and a pharmacist majority of one, its function is to accept/approve standards and audit performance to them. I believe the professional side of the Society should continue to develop and recommend those standards to the regulatory function, hopefully without subsequent modification (although this is the right of the regulatory body). Education must continue to be a component of the professional function.

1 I have always believed the RPSGB should be the registering body for technicians and regret that this was not established years ago. We should create a structure where technicians would feel part of an organisation interested in their development.

11 The retention fee has always been intended to fund the regulatory and Charter objectives of the RPSGB. Over time, the increased costs of the regulatory function have limited the amount available to properly support the Charter objectives. More transparency in Council and Directorate accounts and more published discussion on expenditure should help the membership appreciate where the money goes and why.

Continued on page 32

RPSGB Council elections

Continued from page 31

Digby Emson
Community pharmacy

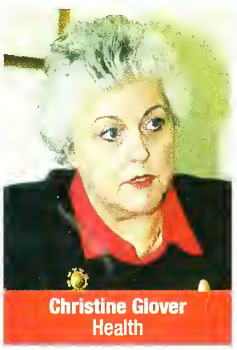
2 The Society is unique in its dual professional and regulatory role. It has a good track record and a valued reputation as a regulator. It gains strength from its dual role. I believe many members would be disappointed if this were lost. However, we must reflect the modern requirements of a regulator and ensure transparent processes which reflect the public interest. The Society's current Modernisation Steering Group will produce recommendations for the future. It will be fundamental in determining the future role of the Society.

3 The public values the ease of access to help and advice currently provided by community pharmacy. I believe it would be inappropriate to reduce that through the non-availability of the pharmacist. More POM-P switches are probable in the future. They are likely to demand more professional intervention, in a similar way to EHC. We should build on this strength of front-line accessibility, not diminish it.

6 I believe the profession and the public have a right to information about Council debates, and decisions. There should be closed sessions only in exceptional circumstances.

Robert Gartside
Community pharmacy

The interests of the members of the Royal Pharmaceutical Society are identical to the interests of the profession of pharmacy because the members *are* the profession. It necessarily follows that the Society looks after the profession by looking after the members. The regulatory process should be operated so as to further the interests of the public and the members so the best service to the public is synonymous with the best conditions for pharmacists and the practice of pharmacy.
This will call for clinical governance but present conditions for pharmacists must be ameliorated in the public interest. Workloads and working hours are threatening safe working.
Pressures on the NHS create opportunities for pharmacists to move out of medicines supply and into medicines management where their specialist skills and knowledge can most profitably be used. But the right place for pharmacists is in pharmacies, and it is there that they must practise these new skills of medicines management based on existing knowledge.
Inevitably, this must mean greater reliance on technicians for the mechanics of medicines supply; it is essential that the technicians are registered and regulated by the Society so as to ensure that their training fits them to work with pharmacists.



Christine Glover
Health

Of the questions asked, supervision is the most contentious. Pharmacists will have to be on the premises for the foreseeable future. However, they will be offering medicines management and other services, so they may not be "available on demand" as they are now.
Patients will have to adjust their expectations of the pharmacist, both in terms of availability and the services they expect to get.
Representation on Council is a crucial part of the modernisation programme. Employees are only one of the under-represented sectors.
The time commitment for Council is also a growing problem, as everyone has more demanding jobs and greater pressure in the workplace. Achieving a balance of background, age and experience, and innovation on Council is going to be difficult.
The need to develop CPD properly and ensure that it is appropriate for all sectors of the profession is an enormous task.
CPD requirements for those working in the hospital and community sectors are relatively easily understood, but a lot of effort and work are going to be needed to cater for everyone else.
This is certainly going to need investment.

Dr Gillian Hawksworth
Community pharmacy

3 While supporting pharmacy development, I think it is important, in the public interest, to think carefully about how progress can be made through delegation. The public and patients have come to expect pharmacists to be accessible without an appointment and, more recently, for the sale of medicines such as EHC or the supervision of methadone. Other healthcare professionals, such as district nurses, expect the availability of pharmacists to supply CDs in an emergency. The pressure on practising community pharmacists is mounting with the increased responsibility of developments linked to accreditation based on our core role and the deregulation of more potent medicines. The absence of the pharmacist may in some cases impede these developments. I believe that skill mix is very important and in the future, when enough accredited technicians are available, some pharmacists may decide to operate through written standard procedures. But I suspect many community pharmacists may not be happy to make this decision for a long time.

4 As a pre-registration tutor I will be involved.

Patricia Hoare
Community pharmacy

4 Yes. It's a matter of leadership by example. The membership should be confident that Council members are competent practitioners in the area declared in their election statement. Council members cannot expect the membership to find the time and resources to do what they cannot do themselves. It won't be easy for anyone, especially Council members who have lost touch with day-to-day practice. At present, it's up to the membership to decide who they want to represent them and how they want to be represented. Modernisation could change all that.

8 What? Give up all that valuable real-estate within creeping distance of the corridors of real power? No. It's the Society's greatest asset and Council should be vigilant as guardian on membership's behalf. Lambeth's still on the same planet, even if some of its emanations might lead us to believe that it is not!

10 Yes. We need a transparent, democratic process to engage the support of the membership in the future policy and direction of the Society. Anything would be better than the current process of a few Council members choosing the president behind closed doors.

Continued on page 34

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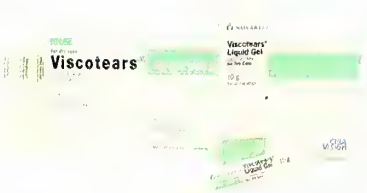

Further information is available from: Novartis Ophthalmics plc, Frimley Park Hospital, Portsmouth Road, Frimley, Surrey GU16 7UA. Tel: 01276 692255

/ISCO/014/002

Continued from page 32

Clive Jackson
National policy development

1 Pharmacy technicians play an increasingly important role in the delivery of pharmaceutical services by providing professionally-based technical input. As qualified individuals providing professional services, government will require them to demonstrate continuing competence through registration. Recent legislation could provide a range of options for professional registration. It is in pharmacy's best interests that this group of colleagues is kept within, and co-ordinated by, our profession.

4 The CPD programme will change, based on experience gained in the first wave. Subsequent, modified waves should also include Council members. I propose around one third of Council and relevant Education Committee members should be involved in each early wave.

11 Not yet. I believe the intention is to spend the additional revenue broadly as set out. However, because a range of options relating to the Society's future roles is out for consultation with members, details of how our fees will be used clearly cannot yet be defined (unless the result is a foregone conclusion). A business plan should be available to members once the Society's medium term direction is finalised.

Hemant Patel
Community pharmacy

The pharmacy profession is under-prepared to cope with the following rapid and fundamental changes:

- (De)regulation: the loss of RPM; review of the control of entry regulations; re-classification from POM to P to GSL; possible changes in rules applying to prescribing and advertising of medicines, supervision; changes in NHS contract and the impact of *Pharmacy in the Future*.
- Devolution of power to the home countries and the local organisations.
- Devolvement of monies to re-organised local organisations.
- Demarcation of professional boundaries and up-skilling of support staff.

Central to all these changes is the patient. There is urgency in delivering services through better application of new technologies, resources, and communications, eg a change in the GP contract is moving responsibility from the doctor to the practice to allow more specialisation and flexibility in the local system.

Failure to understand the impact of these changes at local level is deeply worrying. Even more worrying is the inability of the Society to influence events at local level. I have an enviable record of inspiring, action-oriented leadership I can help, if you want me to.

Peter Schofield
Community pharmacy

2 The Society is the only body capable of representing the interests of all pharmacists, and the modernisation process must reinforce this. With imagination, and government consent, it is possible to achieve both vigorous and effective representation and transparent and responsible regulation.

We seem to be being led down one particular route, while more imaginative and acceptable options are possibly ignored. The process of modernisation must be consensual, democratic and transparent, and led and controlled by full Council.

6 No: as far I can ascertain, deciding whether material is discussed in open or closed session is a decision of the President and Secretary. If this is so, full Council must agree and if necessary put any contentious issues to democratic vote before debate.

Confidential material must be kept t an absolute minimum. Council must reassert its overarching authority.

7 Regrettably employee pharmacists have never been represented. Although not an RPSGB responsibility, the most members ar employees, and this places a moral duty on the Society to ensure employee's interests are considered whenever conflicts of interests aris

Ashok Soni
Community pharmacy

Given the current debate regarding the future role of the Society, I would instinctively vote for it to be solely a regulatory body. I believe the Society must recognise its faults and repair its relationship with members. For the Society to continue to represent all pharmacists there must be a change in attitude. Clarity and information exchange create an environment of trust which promotes integration between members and the Society. Currently it is too secretive. It must become more transparent by allowing greater access to its activities and using closed sessions only in exceptional circumstances. This would help members understand how and why the Society acts as it does. There is an obvious need to act in the public interest but the Society must recognise that the vast majority of pharmacists do the same. It must acknowledge the various strands of pharmacy. One way to achieve this would be by promoting community pharmacy practice at the BPC conference, which appears to have slipped down the agenda over rece years. The Society should be promoting all branches of pharma practice equally and acting for the common good of our profession to enhance its standing within the healthcare team.

Philip Walton
Community pharmacy

I believe that one of the most contentious issues in the modernisation programme is that of technician checking. Friends in other professions see no problem with using their equivalent of technicians as they see fit, so I have difficulty seeing why, if properly managed, pharmacy should have any problems either. Why should pharmacists have to check repeat dispensing when they have made all the checks necessary to ensure safety and they are confident of the abilities of their technicians? Pharmacists should be allowed to use their staff as they see fit.

I do see problems arising if decisions rightly made in the dispensary are made by owners or operators at a distance. Pharmacists should be checking on the multitude of other requirements for safe pharmacy operation and clinical governance, and spending more time directly dealing with patient issues and extended roles.

Technicians are not pharmacists a anybody who tries to use them beyond their capability will be courting disaster. I believe that the pharmacist must retain responsibi for everything that leaves the pharmacy he or she is in charge of but the fact that proper dispensing protocols were in place would act mitigation in error.

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3. Is he aware of the payment methods of the PPA?	❑	❑
4. Is he aware of the average stock holdings of retail chemists of similar size to yours?	❑	❑
5. Is he interested in your business? And the future of your business?	❑	❑
6. Is he imaginative and proactive?	❑	❑
7. Does he guide you on how to increase your profits?	❑	❑
8. Does he insist on and help you prepare quarterly management accounts so that you know what profit you are making? What tax you will have to pay and discuss your profit margins with you so that you can work towards improving these and therefore your net profit?	❑	❑
9. Does he have contacts in the pharmaceutical industry with stock takers, EPOS providers, shop fitters, purchase/sale agents, and specialist finance providers?	❑	❑
10. Is your top rate of tax 20%? If not, why not? Are you therefore paying 40%?	❑	❑
11. Has he reduced your tax liability by 50% annually by restructuring your business. Average tax savings would be about £8,000 p.a.	❑	❑
12. Has he suggested the possibility of setting up a personal or company pension scheme (SIPPS or SSASs)? This would enable you to get tax relief and allow you to purchase commercial properties in your pension fund, without having to pay capital gains tax	❑	❑
13. Can he set up employee benefit trusts, allowing you to obtain a full tax deduction for payments made e.g. payments of £50,000 can reduce your tax liablility by about £10,000	❑	❑
14. Can he set up an ERP? There are significant tax advantages of this scheme if set up correctly.	❑	❑
15. Has he set up offshore companies and trusts that allow you to accumulate vast amounts of wealth totally tax-free?	❑	❑
16. Does he help you plan to keep your wealth? Have you done your Inheritance tax planning?	❑	❑
17. Does he plan for the future sale of your business? The worst scenario should be a 10% tax liability, the best is no tax liability.	❑	❑
18. Do you receive advice throughout the year on how to reduce your tax bills?	❑	❑
19. Does he help you to source commerical properties?	❑	❑
20. Does he prepare your accounts and tax returns on a timely basis?	❑	❑

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FREE LEGAL ADVICE

Chemist & Druggist's web site – *www.dotpharmacy.co.uk* – has introduced a service that offers pharmacists free legal advice from a leading solicitors' firm.

The service – dotLaw – is being run with the co-operation of Charles Russell, whose specialist legal fields include pharmacy matters.

Pharmacists are advised to e-mail their questions to – *pharmlaw@ubmint.com* – along with their full name and the name of their pharmacy. The latter two detail are for *C&D*'s records only – pharmacists' identities w be kept anonymous when the answers are published

All the questions and Charles Russell's replies, which will be available in two working days, will appear o a new dotPharmacy page called dotLaw.

Products and services

Appointments

Hiten Rawal

Pharmacist **Hiten Rawal** has joined the board of Nucare plc as retail director. He will be responsible for developing Nucare's wholly owned pharmacy chain.
There are immediate plans to expand the five-strong chain to six, and "up to 50 in the foreseeable future".
Leeds-based BR Pharmaceuticals has appointed **Roy Tanton** as production manager.

Danger: anoraks!

Doctors in Birmingham have proved what many people have known for a while – anoraks can be bad for your health.

Their research has revealed that the outerwear article so beloved of trainspotters can be dangerous to both wearer and other road users, as having the hood pulled up makes it difficult to see other people.

The research, published in the *Journal of the Royal Society of Medicine*, measured the binocular visual field of healthy volunteers while wearing four different styles of anorak (there are four different styles?).

Crossing the road, anorak wearers may find their field of vision is more than halved, according to ophthalmologists at the Birmingham and Midland Eye Centre.

"Campaigns to reduce road traffic accidents have paid little attention to the way headgear could interfere with vision," says the report.

Loss of street credibility was not reported as a side-effect of anorak wearing.

Living it up at the UCA annual conference

Pictured is PSNI council member Dr Kate McClelland (left) providing her husband Tom with some dietary advice, assisted by Michelle McCorry, Northern Pharmacies' LHSCG liaison officer. See next week's *C&D* for a full conference report

The UCA conference at Killadaes, Co Fermanagh, provided its usual mix of tall stories and practical business. Delegates were impressed by tales that the APS team, as the event's main sponsor, had arrived at Enniskillen Airport in its own private jet.

And the lads from Melernons were rumoured to be on a private yacht on Lough Erne, awash with copious supplies of orange juice.

What not to write in a patient's medical records was illustrated with some real life examples by clinical barrister Rosemary Wilson, to wit:

- this man is obviously a malingerer and what he needs is a toe up the ****
- her husband seems surprisingly sensible
- I've met the patient, I've met his wife, I've met the children and their pet rabbit and, of all of them, the pet rabbit seems the most intelligent
- vaginal packing out. Doctor in.

UCA president Siobhan O'Reilly was showing latent feminist tendencies during one of her presentations, but what would the sisterhood make of this quote: "A woman is like a teabag – you never know how strong she is until you put her in hot water"?

Join our journa – *C&D* seeks willing slave...

"I enjoyed all I learnt at *C&D* a regret only being able to spend month there. I would recomme a placement to any pharmacy students interested in journalis or alternative careers within pharmacy," said Kathryn Mars after surviving a work experien stint with *C&D* last summer.

Why not follow her advice an come and join us for a fun-fille month this summer?

We're looking for an enthusia pharmacy undergraduate who would enjoy working on all sections of the magazine, including writing news, researching forward features, attending press events and mak coffee while we all sit back with our feet up. Start dates are flexible(ish) and our generous editor is even prepared to pay you.

This fantastic opportunity w give the successful applicant a chance to gain a broader view o the world of pharmacy, help reinforce some aspects of their studies and raise awareness of alternative career paths open t pharmacists.

News editor Charles Gladwi looking forward to receiving C and a 200 word statement telli him why you're the most suita candidate. Send them to the Tonbridge address at the front the magazine or to *cgladwin@cmpinformation.com*

Tax breaks can improve your health – but will the UK follow US lead?

With LPS now offering pharmacists in England the chance to flex a bit of entrepreneurial muscle, and Gordon at number 11 emptying his wallet for the NHS, how about tax breaks for those fighting for better health?

Americans who have been medically diagnosed as obese are now able to claim, as a tax-deductable expense, the cost of diagnosis, mitigation, treatment or prevention of the condition.

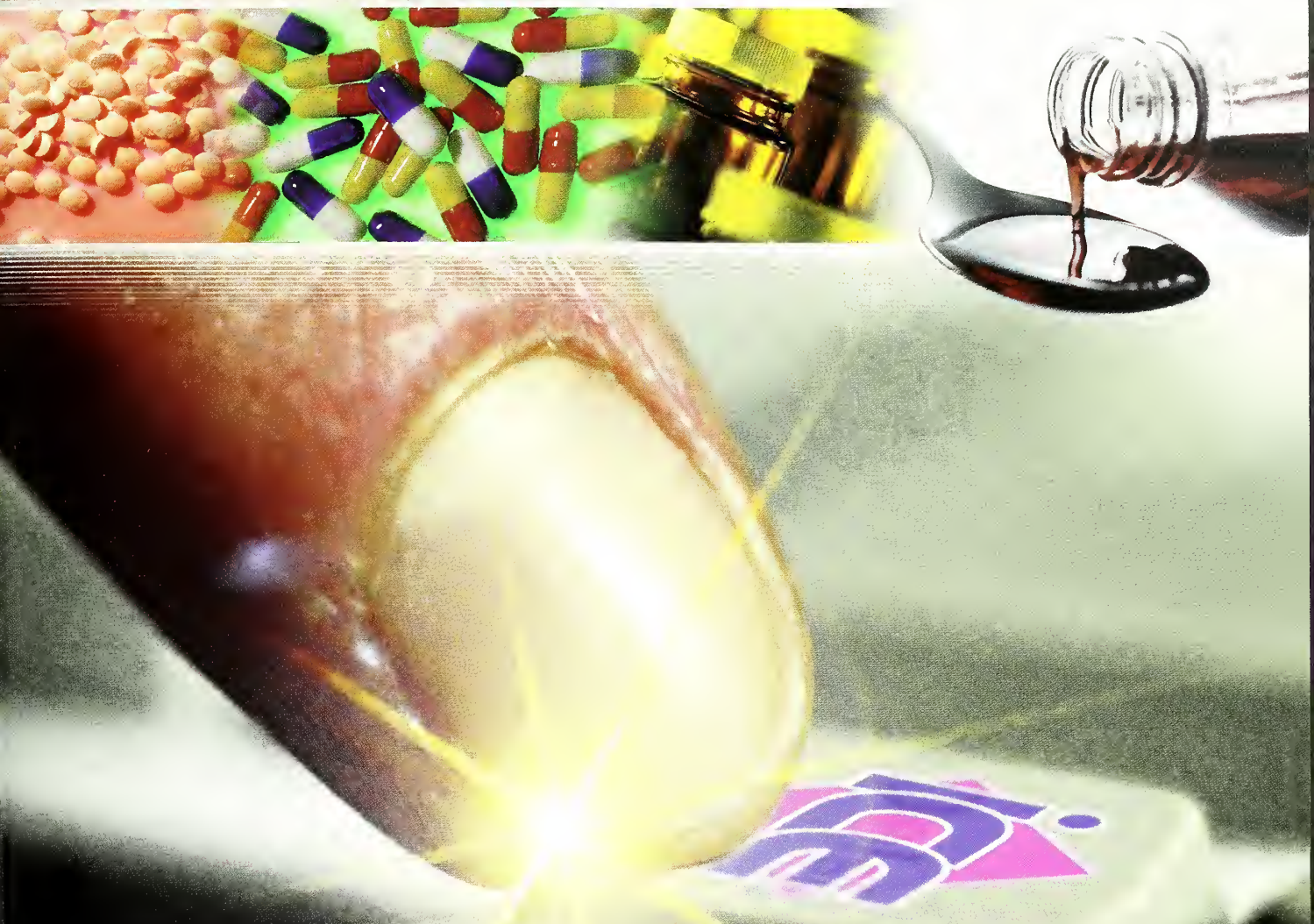
Shares in Weight Watchers reportedly rose 5 cents after the ruling by the Internal Revenue Service.

Four months ago the US Surgeon General announced that obesity was a national epidemic, with 35 per cent of adults being overweight.

So will Gordon cough up for membership of the local gym, reimburse the cost of all those low calorie foods, or pay for attendance at Weight Watchers?

Don't hold your breath!

It was a sunny day in St Albans, hence the furrowed brows on the face the members of the NPA board gathered for this rare group photo fro by NPA chief executive John D'Arcy, new vice chair Hemant Patel, chairman Terry Hannawin and treasurer Wally Dove. But can you nam the rest? They are, after all, making decisions on your behalf...



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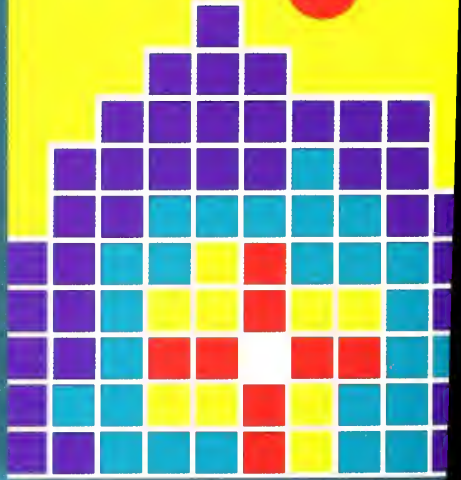

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